

Patient Responsibility and Consent to Treat

As you are aware, our office files only specific insurance companies for our patients as a courtesy. Filing of insurance claims for you does not relieve the patient of the financial responsibility for the services rendered by our physician. We take great pride in caring for our patients and insuring quality medical care is given. However, the insurance company will only pay for services that are covered under your insurance policy, with no exception. Our office will bill you for any uncovered services provided as well as any co-insurance, co-pay, or deductible amount. It is the patient's responsibility to know your insurance coverage. If you do not have your insurance information available at the time of service, the full office visit fee will be due at the time of service. **NO EXCEPTIONS.** We will later file that date of service for you and upon receipt of an insurance payment will refund any overpayment due to you.

Dr. Baker is trained and board certified in Family Medicine, but has spent his entire career devoted to the treatment of cosmetic and medical skin related conditions, including laser surgery. His training does give him some advantages in the treatment of many pediatric conditions and in various surgical techniques. In the event that a difficult, rare or resistant skin disorder is persistent, a second medical opinion may become necessary, and if recommended, or a transfer of care is necessary, your patience and cooperation is appreciated.

Dr. Baker and his staff believe in prompt, quality medical care. We make it a priority to see urgent need patients as quickly as possible, often the next business day. We also make it a goal to see our patients as close to their appointment time as possible, taking great pride in the timeliness of our care, although emergencies and surgical complications do occur on occasion which may delay your care. This does mean, however, that we require the same desire for punctuality from our patients. There is a **\$50 NO SHOW FEE** that will be billed to the patient for visits that are not cancelled or rescheduled 48 hours prior to the appointment time. This is to ensure that we can provide you timely care in an efficient manner. We appreciate your business and we are dedicated to providing quality medical service.

I understand the above policy and will take financial responsibility for my bill if my insurance does not cover the services performed.

Signature _____ Date _____

My permission is given today for any medical treatment including, but not limited to, examination, injections, diagnostic testing or medical procedures as deemed advisable by the members of Dermatology Realm and Family Practice.

Signature _____ Date _____