FINANCIAL AGREEMENT

ASSIGNMENT OF BENEFITS:

I authorize payment directly to the physicians of Patient Preferred Dermatology Medical Group, Inc. for medical insurance benefits payable to me under terms of my policy but not to exceed the balance due for services performed during this period of treatment.

MEDICARE:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carrier any information need for this or a released Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for physician services to the physician or organization furnishing the services. This authorization is valid until revoked in writing.

_____ _____

Patient Signature *Date*

PRIVATE INSURANCE & MEDIGAP POLICIES

I authorize _____ Insurance Company to make
(Name of Insurance Carrier)
payment of authorized benefits to be made on my behalf. I assign benefits payable for physician services to Patient Preferred Dermatology Medical Group, Inc and their affiliates furnishing the services. This authorization is valid until revoked in writing.

_____ _____

Patient Signature *Date*

FINANCIAL AGREEMENT:

For and in consideration of services rendered, I agree to make in-full prompt payment to Patient Preferred Dermatology Medical Group, Inc. when billed for any and all charges not covered or paid by valid insurance benefits.

Payment for Co-pays and Deductibles are due at the time of service. All account balances are due upon receipt of your statement. For your convenience, our office accepts cash, checks, Visa, Master Card, Discovery and American Express.

Returned item fee is $25.00. In the event, your account is unpaid and assigned to the collection agency; a $30.00 administrative fee will be applied to the account.

I understand and agree to the above financial policy.

_____ _____

Signature of patient/guarantor *Date*