Northern Arizona Dermatology Center

CONSENT TO TREAT A MINOR

If the patient is a minor (*under the age of 18*), the parent or legal guardian must read, complete, and sign the following forms: **Consent** (*page 1*) and **Financial Policy** (*page 2*).

This form is required to allow Northern Arizona Dermatology Center to evaluate, treat, and bill for medical services provided to the minor.

I, _____ (*Printed name of Parent or Legal Guardian*), consent to have Northern Arizona Dermatology Center to conduct examinations and perform procedures as are medically required and administer treatment and medications as deemed necessary or advisable to the minor noted below. I have also read and signed the **Financial Policy** (*page 2*).

Minor Name: _____ Date of Birth: _____

I grant permission for the following individual(s) to accompany my child to their appointment at Northern Arizona Dermatology Center:

Name: _____ Relationship to Minor: _____

Name: _____ Relationship to Minor: _____

Name: _____ Relationship to Minor: _____

Date: _____

Signature of Parent/Legal Guardian: _____

Telephone Number: _____

Northern Arizona Dermatology Center

FINANCIAL POLICY

Your signature below authorizes the release of medical information necessary to process your insurance claim as well as authorizes your insurance company to make payment, based on your benefits, to Northern Arizona Dermatology Center as provider of services.

All patients are expected to pay office visit co-payments in full on the day of the services. If you have a deductible to meet, we will collect a deposit towards your deductible at the time of service and will apply it to the deductible amount process by your insurance. You will be billed for additional amounts due. If we have over-collected, a refund will be issued to you.

Appropriate insurance companies will be billed, and you will be sent a statement if there is any patient responsibility after your insurance processes. Statements are considered due and payable upon receipt. If full payment is not possible, please make financial arrangements with your patient billing department. In addition, insurance companies may deny payment for a variety of reasons including, but not limited to, medical necessity, cosmetic procedures, preexisting conditions, and non-covered services. In the event of your insurance company returning a non-payment for non-covered or patient responsibilities, the patient (or parent/guardian) commits to full payment for the rendered services.

The parent/legal guardian who brings in a minor child and signs below will be responsible for all charges not paid by insurance. We do not forward bills to other parties regardless of court rulings or divorce decrees. We also do not participate in disputes between divorced parents.

SELF-PAY PATIENTS: Payment in full will be expected at the time of check-out. We make every attempt to finalize your charges at the time of check out. However, if there are extenuating circumstances and the provider has not finalized your charges completely, we will call you to get authorization to collect any additional amounts that were not collected at time of check out.

Cash, Checks, Visa, MasterCard, Discover, American Express, Care Credit, Debit Cards, or Health Savings Account Debit Cards may be used for payment. In the event payment is not received within sixty (60) days of service, Northern Arizona Dermatology, P.C. may contract with an attorney or collection agency.

We maintain credit/debit card information on file. Should we need to run your card, we will obtain your verbal agreement to do so.

PURCHASED PRODUCTS: Please be advised that all sales are final on products purchased from our facility and are not eligible for a refund or exchange.

By signing below, patient (or parent/guardian) acknowledges the following:

I have read, understand, and agree with the Financial Policy.

Patient or Legal Guardian Signature: _____ Date: _____

Patient or Legal Guardian Printed Name: _____

Northern Arizona Dermatology Center

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