MID-CHARLOTTE DERMATOLOGY
6406 Carmel Road, Unit 309
Charlotte, NC 28226
704-367-9777

Consent for Treatment

Consent for Medical Treatment: I am asking for care and I agree to be given all necessary diagnostic tests, examinations, and surgical and medical treatments prescribed by the physician/provider treating me.

Authorization for Release of Medical Information: I give permission to release medical information about my treatment (including copies of my medical records) needed for payment of my insurance claim or for my continuing care after I have been treated. I reserve the right to revoke this consent at any time, and I understand that any revocation will be effective no earlier than the date of my notice.

Authorization to Pay Benefits to Practice: I authorize and request payment of my medical benefits directly to Mid-Charlotte Dermatology. This authorization will cover all medical services rendered until a written notice of cancellation is received in this office. This does not apply to patients with insurances with whom the practice is not contracted and who therefore pay for services "up front" and submit directly to their insurance for reimbursement.

I understand that the amounts paid by my insurance company to the practice for specific services rendered may change from time to time and that any payment amounts requested at checkout or insurance adjustments appearing on my visit summaries and statements are estimates. As such, upon receiving final accounting and payment from my insurance company, an additional payment may be required of me to settle my account.

If I am on Medicare, I certify that I have given correct information on my application for payment under Title XVIII (Medicare) of the Social Security Act. I ask that any authorized Medicare benefits be paid to Mid-Charlotte Dermatology on my behalf for services furnished to me by my provider. I give permission to release any of my medical information or any other information needed by Medicare and their respective agents, in order to determine the benefits to which I am entitled.

Financial Agreement: I understand that if my insurance is not one filed by Mid-Charlotte Dermatology that payment is expected at time of service. I understand that it is my responsibility to obtain the necessary approval for the provider's services, if my insurance requires precertification for those services. I understand that I am financially responsible for the amount of my bill. I understand that I am also financially responsible for charges **NOT** covered by my insurance.

_____ _____

Signature of Patient Signature of Responsible Party

_____ _____

Date Relationship to Patient

_____

Witness Signature

EDITED 4/2018