MICHAEL A. SCANNON MD, SANDY SNYDER PA-C,
JESSICA HAGE PA-C

PATIENT INFORMATION

Deductible/Co-Insurance/Co-Pay Policy

Most health insurance carries require the patient to pay for a portion of services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. If your responsibility is a "Co-Payment," you will be responsible to pay that amount (usually listed on your ID card). If your responsibility is a Deductible or co-insurance, we will estimate your responsibility, based on our anticipated reimbursement from your insurance company.

X Patient/Guarantor Signature _____Date _____

Self-Pay

I do not have health insurance and I will be responsible for all medical services rendered at Florida Dermatology and Skin Care Specialists, PL. I agree to pay Florida Dermatology and Skin Cancer Specialists, PL for the full amount of charges related to the office visit and any treatment/procedure rendered to me or to the above named patient at each visit.

X Patient/Guarantor Signature _____Date _____

Cancellations and No-Show Policy

We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. Our practice is very busy, and if you are unable to keep your appointment, we would like to offer that slot to another patient.

X Patient/Guarantor Signature _____Date _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Florida Dermatology and Skin Cancer Specialists, PL, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

X Patient/Guarantor Signature _____Date _____