Wolff Dermatology

18 Congress St. ,Suite 2, Saratoga Springs, NY 12866

T (518) 350-4694 F (518) 309-6563

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information

I understand and agree that payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers will be made to me or on my behalf to the provider or supplier of any services furnished to me by that provider or supplier. I authorize any holder of my medical information to release it to Wolff Dermatology, the Health Care Financing Administration (HCFA), the listed insurer and/or agents of the company and/or the listed responsible person(s), and any information necessary to determine my benefits or the benefit for the related services. If my insurance plan does not participate with Wolff Dermatology, or if I am a self-pay patient, assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification

In consideration of services provided to me by Dr.Wolff and Wolff Dermatology, I agree to be financially responsible and to pay charges for all services ordered by my provider. I understand that any balance due as a result of being uninsured or underinsured is payable. I further understand that if I fail to maintain consistent payments, I may be barred from creating a follow up appointment. I understand that if my insurance has a precertification or authorization requirement, it is my responsibility to notify the carrier of servicesrendered according to the plan's provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I may be responsible for all balances.

Consent to Treatment

As patient of Dr. Wolff and Wolff Dermatology, I voluntarily consent to the rendering of such care and treatment as the providers and personnel, in their professional judgment, deem necessary for my health and wellbeing. My consent shall include medical examination and diagnostic testing including, but not limited to, minor surgical procedures, scaping, bacteria/viral cultures, pharmaceutical injections, patch testing, and image documentation. My consent shall also include the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither Dr. Wolff nor Wolff Dermatology staff has made any guarantee or promise as to the results that may be obtained.

Consent to Call

I understand and agree that Dr. Wolff and staff may contact me using automated calls, emails, and text messaging sent to my landline and mobile device. These communications may notify me of, test results, appointment verification, outstanding balances, or any other communications from Dr. Wolff and Wolff Dermatology.

I hereby acknowledge that I have read Wolff Dermatologys *Financial Policy, Consent to Treatment, and Consent to Call*. I hereby agree to the to the above terms.

Printed Name of Patient: _____

➔ Signature: _____ Date: _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent