Academic Dermatology of Nevada
The smart approach to skin disorders.

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Practice Policies & SIGNATURE ON FILE

I hereby consent to and authorize all treatment that may be advisable or necessary. I will inform this office of any changes in my medical history, insurance coverage, telephone number an/or address as they occur. I certify this information is true and correct to the best of my knowledge.

I UNDERSTAND AND ACCEPT THAT I AM UNLTIMATELY FINANCIALLY RESPONSIBLE FOR ALL EXPENSES AND CHARGES INCURRED FOR SERVICES PROVIDED (REGARDLESS OF MY INSURANCE STATUS) AT ACADEMIC DERMATOLOGY OF NEVADA, 2839 St. ROSE PARKWAY, SUITE 100, HENDERSON, NV 89052.

PLEASE NOTE PAYMENT IS EXPECTED AND DUE AT THE TIME OF SERVICE FOR "YOUR PORTION" OF CHARGES; that includes and co-pays, co-insurance, any remaining deductible or certain cosmetic services. If you do not know the amount of your co-pay, 20% of the total charges will be collected at the time of service. For your convenience, we accept cash, personal checks with a check guarantee card (and driver's license) and VISA, MASTER CHARGE or DISCOVERY.

As a courtesy to our patients, we will bill your insurance company. In order to do so, we must have updated and accurate insurance information. If a completed claim form is required to accompany our bill, we must have that completed form at the time of your office visit. Please be aware that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Your account with this office is your responsibility whether or not your insurance company pays.

We are preferred providers for most managed care organization; which means we have agreed to accept reduced reimbursement for our professional service. However, some insurers may use a variety of tactics to avoid, delay or inappropriately pay for our services, in addition to the already reduced ("contracted") fee schedule that we have agreed to. As your advocate, we will make every effort to obtain appropriate payment from your insurance company. However , if your insurance company has not paid your account in full or made any kind of satisfactory arrangement for payment or otherwise within 60 days of your first bill, (or we are unable to locate/notify you of your account status despite reasonable effort) you will be turned over to our collection agency. If your account is referred to a Collection Agency, you will be responsible for all Collection costs (40% or more of the amount owed), Attorney fees, Court costs, Service Fees & associated Miscellaneous Fees and Costs. An adult accompanying a minor patient (the "responsible party") is responsible for full payment of the minor patient's account.

Because of the quality of care that we provide for each of our patient, our practice is extremely busy. Please help us to better serve you by keeping all scheduled appointments. If you respectively (i.e. twice or more) fail to show for your appointments or cancel with less than 24 hours advanced notice, our policy is to charge $50.00 for such missed appointments. There will be a $50.00 charge for returned checks. Refunds of $5.00 or less will not be refunded unless requested by the patient by phone or in writing.

I herein authorize payment of medical benefits to Curt Samlaska, MD, FACP, FAAD & Associates, LLC, when an assigned claim is filed. Further my signature authorizes Curt Samlaska & Associates, LLC to release any medical information necessary to process my insurance claims or as needed by my insurances (if any).

I authorize the use of this form on my insurance submissions, if needed. I permit a copy (of fax) of this authorization to be used in place of this original.

Please let us know if you have any questions or concerns. Our strict adherence to these policies serves to enhance our physician/patient relationship. My signature below indicates that I understand and accept these policies and obligations.

PRINT NAME: _____ **SSN:** _____

_____ **Date:** _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN