Dermatology Associates, Beth Honl, M.D.
4141 31st Ave. S., Ste. 103
Fargo, ND 58104

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for the above stated to furnish medical care and treatment to ____________ as considered necessary and proper in diagnosing or treating his/her physical and mental condition. This includes cryotherapy, cautery, biopsies, minor excisions and other procedures deemed medically necessary by the physician. I understand that the physician will discuss with me prior to any procedure or treatment and this will be documented in my medical record. This shall be valid throughout all treatment for this condition and/or disease process.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, from Medicare, Medicaid, private insurance and third party payers, to the above stated. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

FINANCIAL POLICY STATEMENT

We will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are provided. If your insurance carrier does not remit payment or notification to us within 60 days, the balance will be due from you. In the event that your insurance company requests a refund of payments, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal **usual and customary fee schedule** you will be responsible for the difference remaining.

Self pay services may be requested due on the date of service.

The above does not apply to Workers' Compensation patients. However, if you claim workers' compensation benefits and are subsequently denied, you may be held liable for the total amount of charges for services provided.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

Signature**:**