PERIMETER
DERMATOLOGY

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Patient Name: _____ DOB: _____

Please read, print, sign and date the bottom.

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

To help prevent identity fraud and fraudulent use of insurance information, it is a policy of this office to request your insurance card each time you have an appointment with our providers, along with a photo I.D. We will verify this information at each visit, so be prepared to present your insurance card and your p hoto I.D. when signing in. Please notify our staff if demographic or insurance information has changed.

Payment for medical services is expected on the day of service. If you participate in an insurance plan accepted by this office you will be responsible for your copayment and/or deductibles at the time of service. As a patient courtesy we file with most insurance plans. Should there be a remaining balance on your account, we will send you a bill. Please note this office only sends two (2) statements for payment. If payment is not received, your account may be placed for collection without further notice. If your account is placed with a collection agency a 35% fee will be added to cover collection costs.

Cosmetic procedures such as Botox, facial fillers, ear piercing, skin tag removal and chemical peels, including aesthetician and laser services must be paid in full on the date the services are performed. Some of our topically applied products, such as Private Label products, come with an unconditional return guarantee within 14 days of purchase. You will receive a full refund of the purchase price (less shipping and handling charges if applicable) should you find the product does not meet your expectations. Products that cannot be returned to our office include Latisse and sun hats.

The office does not send year end statements for income tax purposes. At your request we will provide you with a receipt at the time of service. If the charges are not yet finalized we can email you that receipt if requested at checkout.

I authorize, if medically necessary, the use of photographs of me or parts of my body for the sole purpose of medical care. The photographs will be kept confidential within my personal medical history file at this office.

Your signature below signifies your understanding and willingness to comply with this policy.

_____ _____
Patient/Parent/Guardian Signature Print Name

_____
Date