JOLIET MORRIS DERMATOLOGY
CARY ANN JENKINS, MD

PATIENT AGREEMENT

Thank you for choosing us to be your medical provider. We are dedicated to ensuring your good health and we want to make certain you completely understand our financial policies.

We have contracts with many of the insurance companies that we accept. Even though we take most of the major medical insurance plans, we may not be on the type of plan that you have selected. It is **your responsibility** to be sure of proper coverage before being seen by our providers. Please note:

- Your co-pay is expected at the time of your visit. Any cost sharing such as co-payment, coinsurance and/or deductibles are the responsibility of the Patient and/or Responsible party.
- If you do not have insurance, payment in full is expected at the time of service.
- Patients with an outstanding balance greater than 30 days or more overdue must make arrangements for clearing balances prior to scheduling future appointments. To make arrangements to pay your bill, please call our billing office at 1-866-701-4710.
- Scheduling is a vital part of our practice and the doctor's ability to see patients efficiently. We kindly ask that you give us a 24-hour notice if you need to reschedule or cancel an appointment.
- Missed appointments will be charged a fee of $50. Chronic missed appointments may result in termination from our practice.
- All returned checks will be charged a non-sufficient fund fee of $35.00.
- For new patients, a photo identification and insurance card (i.e. driver's license, state ID, school ID) must be presented at first visit.
- Whenever a biopsy or other test is done in the office, it is sent out to an outside lab facility for testing. You and/or your insurance company will be billed directly from that lab for those services. It is your responsibility to pay them directly.
- No statement by an employee or agent of Morris Dermatology will contradict, void or nullify this agreement, nor shall the patient rely on any statements or opinions made by Morris Dermatology that patient's insurance carrier will pay the bill.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined.

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Authorization for release of medical records: I authorize Morris Dermatology to release all medical and billing information necessary to secure payment from any insurance carrier, on my behalf.

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Witness signature **Patient/POA/Guardian Signature**