AMERICAN SKIN AND CANCER CENTER, PC

PATIENT FINANCIAL LIABILITY STATEMENT AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that I am personally financially responsible for charges incurred for services rendered by American Skin and Cancer Center, PC if any of the following apply:

1. My health benefit plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at American Skin and Cancer Cener PC and I have not obtained such authorization or referral or I receive services in excess of such authorization or referral.

and/or

2. My health plan determines that the services I receive at American Skin and Cancer Center PC are, in their opinion, not medically necessary.

and/or

3. My health plan coverage has lapsed or expired at the time I receive services at American Skin and Cancer Center PC.

and/or

4. My health plan is not one that American Skin and Cancer Center PC participates in.

and/or

5. I have chosen not to use my health plan coverage

I also understand that I am responsible for all co-payments and co-insurance sums under my health plan.

Please advise us of your correct insurance carrier and provide us with the most up-to-date insurance card. Failure to do so will result in the assessment of a $50 processing fee because of the significant additional efforts required in reprocessing the claims policy. We regret the inconvenience, but the ever-increasing billing costs force us to impose this fee.

Medicare Patients: I hereby authorize direct payment of surgical/medical benefits to American Skin and Cancer Center PC for services rendered by all clinicians at American Skin and Cancer Center PC. I understand that I am financially responsible for any balance not covered by my insurance.

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Records Release: I authorize the release of my prior medical records, if needed to American Skin and Cancer Center.

I hereby give my consent for American Skin and Cancer Center PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (American Skin and Cancer Center PC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. American Skin and Cancer Center PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to American Skin and Cancer Centers PC's Privacy Officer at 25 First Avenue Suite 113 Atlantic Highlands, NJ 07716.

With this consent, American Skin and Cancer Center PC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist in the practice of carrying out TPO, such as appointment reminders, insurance items and ant calls pertaining to my clinical care, including laboratory results among others.

With this consent, American Skin and Cancer Center PC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. With this consent, American Skin and Cancer Center PC may email my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that American Skin and Cancer Center PC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to American Skin and Cancer Center PC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, American Skin and Cancer Center PC may decline to provide treatment to me.

_____ _____

Print Patient Name or Legal Guardian Name Print Guarantor's/Guardian's Name if not the patient

_____ _____ _____

Signature of Patient or Legal Guardian Signature of Financially Responsible Party (Guarantor/Guardian) Date