

Patient Acknowledgements of Bobby Buka MD PC Office Policies

To be completed by ALL PATIENTS. If the patient is under the age of 18, this form is to be filled out by his/her PARENT or GUARDIAN. Please read each item below and initial the space provided.

-Insurance Information / Co-payments and Deductibles

Payment is required for all services at the time they are rendered. If this office accepts my insurance, I understand that I am still responsible for paying any co-payment and deductibles that my insurance does not cover. **I understand that regardless of insurance enrollment, I am ultimately responsible for all costs of dermatologic treatment rendered.** Checks returned for insufficient funds will be charged an additional \$50 fee. Your signature below signifies your understanding and willingness to comply with this policy.

-Referral Information

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed. I understand that any specialty treatments requiring pre-authorization are also ultimately the responsibility of the patient. **I understand that should I fail to present a valid referral, I may be responsible for any charges pursuant to for specialist treatment.**

-Insurance Cards

New patients or those patients who change insurance plans must provide a valid insurance card at the time of the visit. Should you be unable to produce this documentation, patients may pay in full at the time of service and submit the claim to your insurance carrier for reimbursement. I understand that **I am responsible for notifying the office of any changes to my insurance or contact information.**

-Cancellation Policy

Should you be unable to keep your appointment, please contact our office. Failure to contact the office within 24 hours of your appointment will result in a \$25.00 cancellation fee.

-Statement of Financial Responsibilities

As a courtesy to our patients, our office will bill private insurance for surgical procedures. Cosmetic procedures are not covered by insurance and the cosmetic fee is the responsibility of the patient. Any surgery done for medically necessary reasons will be billed separately to your insurance. A statement will be sent out explaining the status of your account, and following statements may reflect any remaining balance. Since the financial responsibility always resides with the patient, we want to keep you informed. For example: if your insurance has not paid within 30 days you may wish to call them directly to confirm payment within 60 days. After 60 days we may no longer pursue your insurance company, but you the patient, for payment.

-HIPAA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Bobby Buka MD PC from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments, or obtain results for you, please indicate their name below.

Name of Individual (please print)

Relationship to Patient

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I acknowledge having received a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

By signing below, I, the patient or parent/guardian for those under the age 18, indicate that I have read, understand, and accept this Patient Acknowledgements listed above and hereby comply with its nature.

_____ Patient/Guardian Signature