Patient ID: _____

Provider: _____

Financial Partnership

All contracted insurance is billed directly to your insurance company as a courtesy of Epiphany Dermatology & Medical Day Spa, LLC (SFD). Any remaining balances for non-covered benefit deductibles, copays and coinsurances are your responsibility. These may be collected prior to any potential procedure. It may take up to three months or longer for your insurance to process your claim, which may delay the charge to your credit/debit card. **We require a copy of a valid credit, debit or HSA card to be kept on file. You will receive an explanation of benefits from your insurance company explaining costs incurred. Monies due to Epiphany Dermatology based on your bill and explanation of benefits will be charged to the card on file upon our receipt of the explanation of benefits.**

Please initial acknowledging the above statement: _____date_____

- We accept cash, check, Visa, Master Card, Discover, American Express, Money Order, HSA cards, and CareCredit.
- There is a $30 fee for all returned checks.
- Out of respect for all patients waiting to see any provider (physicians, physician assistants, nurses or aestheticians), **there will be a $125 fee if you do not show up to any appointment without cancelling the appointment prior to the appointment time.** 48 hour notice is appreciated.
- All accounts that become past due 45 days after your insurance pays, we reserve the right to send your account to a collection agency if the balance is not paid in full within 60 days.
- For all skin lesion removals (i.e. cosmetic or medical), a skin specimen is sent to the pathology lab for testing and to confirm clinical diagnosis. There may be additional charge by the lab, unrelated to any fee paid directly to Epiphany Dermatology & Medical Day Spa, LLC
- A copy of this form will be available at your request.
- I authorize the release of medical information to my primary care or referring physicians, to consultant if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.
- I hereby acknowledge that I have read, understand and agree with the policies set forth by Epiphany Dermatology & Medical Day Spa, LLC and any change made by me will be made only in writing. I give my authorization for the charge of my valid debit, credit or HSA card and my consent for procedure as outline above.

I have had the opportunity to review the Notice of Privacy Practices and consent above for Epiphany Dermatology & Medical Day Spa, LLC. I consent to the medical/cosmetic care and financial agreements above.

_____	_____	_____
Print name of patient	**Signature of patient**	**Date**
_____	_____	_____
Print name of parent/guardian	**Signature of parent/guardian**	**Date**

Reviewed by (provider signature): _____