DERMATOLOGY AND SKIN SURGERY CENTER OF PRINCETON, LLC
JOHN E. VINE, M.D.

PATIENT NAME _____

AUTHORIZATION TO BILL INSURANCE

I, _____, having presented to the office of the Dermatology and Skin Surgery Center of Princeton, LLC do hereby provide consent for evaluation and treatment.

I do hereby authorize the Dermatology and Skin Surgery Center of Princeton, LLC to obtain or release any or all of my medical records to, or from, physician offices, hospitals, labs, free standing medical or surgical centers/clinics or insurance agencies for the sole purpose of information exchange for treatment purposes.

I authorize the medical staff and personnel to release my medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills. I also authorize payments under my insurance programs to be made directly to the Dermatology and Skin Surgery Center of Princeton, LLC for any medical or surgical services provided to me.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Signature (as it appears on Medicare card if applicable) Date

HIPAA ACKNOWLEDGEMENT

You can obtain a copy of Privacy Practices on our website at www.johnvinemd.com patient forms

❒ I hereby acknowledge that I have received or been offered a copy of the Dermatology and Skin Surgery Center of Princeton's "Notice of Privacy Practices" to read, and any questions I had were answered to my satisfaction.

_____ _____
Patient (or responsible party) Signature Date

DERMATOLOGY AND SKIN SURGERY CENTER OF PRINCETON, LLC
JOHN E. VINE, M.D.

PATIENT NAME _____

FINANCIAL RESPONSIBILITY

I furthermore understand that I am personally responsible for all costs incurred during the evaluation and treatment I receive from the Dermatology and Skin Surgery Center of Princeton, LLC and agree to pay for services rendered, in full, regardless of medical coverage or reimbursement. If my insurance carrier requires a referral and I do not present a valid copy to the office, I assume personal responsibility for all charges not covered by insurance. I agree to remit all payments, in full, no later than 60 (sixty) days from the date services are rendered. I further understand that certain fees are payable prior to evaluation and treatment. Payments not received within the 60-day grace period are subject to a monthly late fee of 1% (one percent) of the total charges (12% annually) which may be added to the outstanding balance at the discretion of the Dermatology and Skin Surgery Center of Princeton, LLC

I understand that if I do not show up for my appointment, or cancel my appointment with less than 24 hours' notice, I will be billed $50 for medical appointments. Cosmetic appointments require a non-refundable deposit of $100. I understand that these charges are not billable to my insurance company.

I understand that if I arrive more than fifteen minutes late to my appointment, it will need to be rescheduled.

_____ _____
Patient (or responsible party) Signature Date