PATIENT CARE FINANCIAL AGREEMENT

Kimberly Uhles Hurvitz, MD & Erika Klemperer, MD

The purpose of this agreement is to provide a clear understanding of our appointment cancellation policy. We require at least a 24 hour notification of cancellation prior to your scheduled appointment. Failure to do so may result in a fee.

WE CHARGE A $40.00 (per 15min. increment) FEE FOR MISSED APPOINTMENTS OR FAILURE TO CANCEL 24 HOURS IN ADVANCE.

We appreciate the time that we are able to spend with you. We diligently strive to be prepared and on time for your appointments so that you receive the maximal benefit from your time at Advanced Dermatology & Aesthetics Center. If you cannot make an appointment, please notify us as soon as possible.

I hereby authorize this office to charge my account $40.00 (per 15min. increment) should I fail to cancel an appointment at least 24 hours in advance or miss a scheduled appointment.

NAME: _____

DATE: _____

This agreement has no expiration date.

FINANCIAL POLICY

I hereby authorize treatment by Kimberly Uhles Hurvitz, M.D. and/or Erika Klemperer, M.D. and understand that I am financially responsible for all fees and charges for such treatment whether or not they are covered by my insurance policy. I understand Dr Hurvitz and/or Dr. Klemperer is contracted with some, but not all, insurance plans and it is my responsibility to be aware of the terms and limitations of my insurance coverage. If my insurance policy is through an HMO, I understand it is my responsibility to ensure that authorization has been obtained from my primary care physician **prior** to receiving services from Dr. Hurvitz and/or Dr. Klemperer. If such authorization has not been given, I understand that I will be financially responsible for all fees and charges .

I understand that during the course of my office visit with Dr. Hurvitz and/or Dr. Klemperer, it may be necessary for her to perform additional diagnostic or therapeutic services at her discretion. I understand that charges for these services will be in addition to the regular office charges.

I authorize Dr. Hurvitz and/or Dr. Klemperer to furnish any medical information necessary to process my claim to my insurance carrier and hereby irrevocably assign to the doctors payment for medical services and unpaid balances. I authorize copies of this authorization to be used in place of the original. If my account is referred to an attorney ·or collection agency, I agree to pay reasonable fees and collection expenses. I understand that all balances overdue by 60 days or more will be subject to a finance charge of 1.5% per month on the unpaid balance, whether or not an insurance claim is pending.

I have received a copy of the Privacy Notice from Advanced Dermatology & Aesthetics Center.

This authorization will remain in effect until revoked by me in writing.

_____ _____

Signature Date

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

I authorize treatment of _____ and agree that I am financially responsible for all fees and charges for such treatment.

_____ _____

Parent/Guardian Signature Date

THANK YOU.

KIMBERLY UHLES HURVITZ, M.D. **ERIKA KLEMPERER, M.D.**

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