Dermatology Associates

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policy, our staff is trained to consistently inform you of the financial policies of this office. Payment is required for all services at the time they are rendered unless prior arrangements have been established.
We accept payment in the form of cash, check and all major credit cards.

I authorize the release of any medical information necessary to my Primary Care Physician, Referring Physician and any information to process my insurance claims, applications and prescriptions.

I understand that my medication history and transmission of prescriptions will be obtained by utilizing a protected electronic information exchange.

I hereby authorize the physician to conduct any medical treatment, procedures or photos deemed necessary.

Signature of Patient/Parent/Representative

_____ Date _____

Relationship to Patient_____