Zogg Dermatology, PLC
507-373-2270

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

____________________________ ____

Date Signature

PAYMENT POLICY

INSURANCE: All co-pays are due on the day of the visit. We will make every reasonable effort to help you regarding reimbursement from your insurance company. However, it is your responsibility to provide accurate current insurance information and to know your insurance benefits and policies. Your insurance coverage is between you and your insurance company. Each individual policy is different and special policy provisions may be in effect for you. We have no way of knowing the details of your insurance coverage regarding the need for a referral, coverage issues or policy exclusions. We will submit your insurance claims and provide any necessary information required by your insurance company for payment of your claims on your behalf. If you have individual questions regarding your policy, we encourage you to contact your agent or the company directly.

PLEASE NOTE: All balances due by the patient after insurance processing are due when receiving our statement. If the balance can not be paid in full when receiving your statement, please contact the office to discuss payment options including: cash, money order, check and major credit cards. Care Credit, a medical finance company, is also available upon approval. Delinquent balances are subject to collections and may be turned to an outside collection agency.

PATIENTS WITHOUT INSURANCE: Payment in full is due on the day of the visit.

I have read the above information and agree to abide by the stated stipulations.

Signed____ Date_______________

(Patient or legal representation of patient)

Patient's name (please print)____