"I hereby assign, authorize, and transfer to Waccamaw Dermatology & Plastic Surgery, LLC, all rights, and interest in benefits I may have from any insurance carrier or policy, including but not limited to medical, third party liability insurance coverage and payments, workers compensation benefits, or benefits paid by Medicare or Medicaid. This assignment is intended to include any interest in benefits that I may have relating to this date of service, and any prior dates of service. I direct that any insurance company or other party make payment of such benefits to the Provider. I authorize Waccamaw Dermatology & Plastic Surgery, LLC to collect benefits from any responsible third party through whatever means may be deemed necessary and to endorse benefit checks made payable directly to me. I agree to assume full responsibility for payment, this assignment applies to both past and future medical expenses. A photocopy of this assignment is to be considered as valid and original. The undersigned patient agrees to pay any applicable deductible, co-payments, or any and all other services not covered by the insurance policy. This assignment is valid for a period of one year from the date set forth herein."

I understand that Waccamaw Dermatology & Plastic Surgery, LLC files insurance as a courtesy to me, and I agree that I am responsible for any balance owed on my bill that is not paid by me, insurance company or responsible party. If I fail to pay my bill when due, I agree that this account may be turned over to a collection agency or attorney, and I agree to pay the bill due plus all costs of collection including reasonable attorney's fees.

RELEASE AND USE OF PATIENT INFORMATION

I authorize the release of my medical records, information, treatment and advice, and specific health information to the following:

1. Any insurance company, payer, or other third party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility, available benefits and obtaining payment for services provided.

2. Any treating physicians, their agents and allied health. professionals; to another health care facility upon direct transfer and to my attending consulting, referring and/or primary care physicians for follow up care. I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected.

I understand this information concerning medical care, advice or treatment may include history and physical/diagnosis/laboratory and diagnostic testing, and specific private information.

In return for the services rendered and to be rendered, I hereby absolutely and unconditionally guarantee the payment of all charges associated with services received from the Medical Practice.

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Waccamaw Dermatology & Plastic Surgery, LLC may use and disclose my protected health information. I understand that Waccamaw Dermatology & Plastic Surgery, LLC reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

PERMISSION

Do we have permission to:
Leave a message on your voicemail? _____yes _____no
Leave a message at your place of business? _____yes _____no
Discuss your health with others? _____yes _____no
If yes, with whom: _____ Relationship: _____

_____ _____

Printed Patient Name *Date*

_____ _____

Signature of Patient or Parent/Guardian *Date*

Cancellations for any appointment requires 24-hour notice; should you fail to make your appointment, there will be a $250.00 charge for missed surgery appointments. We reserve the right to charge for other missed appointments.