PENINSULA DERMATOLOGY & LASER CLINIC
Silverdale Gig Harbor Tacoma

Consent for Financial Agreement

Assignment, Release and Financial Agreement

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I understand that I am financially responsible for non-covered services. I also authorize the physician to release any information required. I agree that I will not withhold or delay payment if my insurance company denies payment of any charges or pays the payment directly to me. I have also been informed of the $35.00 fee (per RCW 62A.2-515 & 520) on checks returned for NSF. In the event it should become necessary to place any unpaid balance due for services rendered to me or my family for collection, I/we agree to pay interest, collection fees and should legal action be filed, reasonable attorney fees, filing fees and other costs the court determines proper.

Medicare Authorization

I authorize the doctor to release to the Federal Government or its designated agent information on this or related medical claims. I permit a copy of this authorization to be used in place of the original and request payment of my insurance benefits are made to me or the doctor if assignment is accepted.

Phone Message Authorization

I authorize Peninsula Dermatology & Laser Clinic to leave messages at my home or alternate number I have provided for all administrative issues.

Patient or Guardian Signature: _____ **Date:** _____

Printed Name: _____