Ithaca Dermatology
Kimberly Silvers, MD
821 Cliff Street, Ithaca, New York 14850

Please initial and sign at the bottom:

RELEASE OF INFORMATION:

I AUTHORIZE Ithaca Dermatology & Kimberly Silvers, M.D. to release relevant portions of my medical records to such medical practitioners, facilities, or pharmacies as may be responsible for my subsequent care. I also authorize Ithaca Dermatology and Kimberly Silvers, M.D. to release medical records and billing information to insurance carriers, government agencies or others who are financially liable for all or a portion of my treatment. I further authorize Ithaca Dermatology and Kimberly Silvers, MD to release medical information to others as follows:

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FINANCIAL AGREEMENT:

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. As a courtesy, claims are filed with all insurance carriers. If you are not covered by an insurance plan with which we participate, payment is required for all services at the time they are rendered. For those patients covered by a participating plan, applicable co-payments, deductibles and payments for non-covered services will be collected at the time of service. We accept payment in the form of cash, check, or credit card, In the event that your account must be turned over to collections for non-payment, you agree to pay reasonable attorney's fee and collection expenses. In the event that you must change or cancel your appointment, you will be charged $25.00 if you do not give 24 hours notice.

ASSIGNMENT OF BENEFITS:

I hereby assign payment directly to Ithaca Dermatology & Kimberly Silvers, M.D. and its providers accepting this assignment of all medical benefits applicable and others payable to me. I understand that I am financially responsible to Ithaca Dermatology and Kimberly Silvers, M.D. and its providers for charges **not covered** by this assignment or for any and all charges which the insurance carrier declines to pay in accordance with NYS Law and/or my insurance policy.

______I consent to taking photographs during the course of my treatments at Ithaca Dermatology for my healthcare records.

Patient Signature	Social Security Number	Date
Signature of Parent or Legal Guardian	Social Security Number	Date