Information and Consent for Treatment

As you know, insurance plans and their coverages vary greatly. We try hard to work with our patients to make sure they receive the maximum benefits from their insurer. In order to do this, we must have your current insurance card and insurance information at the time of your appointment. **Without this accurate information you will be responsible for the charges incurred at the time of your visit.**

Some insurance plans may require a referring doctor. If your insurance requires such a referral, you must have that information before or at the time of your scheduled appointment. If you try to obtain the referral when you are at this office and delay your examination, our schedule and all of our subsequent patients will be unfairly delayed. It is your responsibility to get this referral.

Some insurance plans also have a deductible for **"SURGICAL PROCEDURE."** When any type of growth is removed from the skin by excision, biopsy, liquid nitrogen to freeze the growth, including milia extraction and injections, most insurance plans consider this as a **"SURGICAL PROCEDURE." If your surgical deductible has not yet been met, you will be responsible for these charges.**

Any time a growth is removed from the skin, the tissue will be automatically sent for pathology unless otherwise indicated by the doctor. This is considered a separate charge in addition to the biopsy fee. If you should have any questions regarding this process, please inquire before the procedure is done.

If you are not sure of, or concerned about your plan benefits, please advise our staff BEFORE any procedure is performed.

Do we have permission to?

Leave a message on your answering machine at home?	Yes	No
Leave a message at your place of employment?	Yes	No
Discuss your medical condition with any member of your household?	Yes	No

If yes, who: _____ Relationship:_____

I have read and understand the above information. By signing below, I authorize the doctor to perform the procedure indicated and agree to be responsible for any fees my insurance company does not pay.

Patient/Responsible Party X_____ Date_____

I agree that this consent for treatment will remain in effect for the duration of my association with this practice.

Patient/Responsible Party X_____ Date_____

Andrew R. Altman M.D. P.A.
Dermatology and Dermatologic Surgery