The Toledo Clinic | Nahhas Dermatology

Patient Consent to Treatment & Financial Responsibility

I am at least 18 years of age or, if not, I am accompanied by a legal guardian. I hereby consent to and authorize an examination by my doctor and such an assistant or staff as may be assigned by the physician at Nahhas Dermatology at the Toledo Clinic. I authorize Nahhas Dermatology at the Toledo Clinic to fax my records to any physician or pharmacy for the purpose of coordinating or managing my healthcare.

Photography is at times necessary part of planning and evaluating treatment. Patient or responsible party authorize the taking of photographs at the direction of the physician and/or delegate, solely for the documentation purposes and recognize they will be kept confidential unless otherwise disclosed.

We have contracts with many insurance companies to accept assignment of benefits for our services. In order to do this, we must have a valid insurance card and a driver's license or other legal form of identification at the time of the visit or you will be charged as a private pay patient and charges for your visit will be your complete responsibility. You are responsible for knowing your insurance coverage and benefits. Insurance coverage varies from plan-to-plan Nahhas Dermatology at the Toledo Clinic will not waive your financial responsibly if your insurance provider denies payment.

As a service to you, we will file your insurance claim. You will be billed for any amount not covered by the insurance company, including deductibles, surgical/pathology deductibles and co-insurance. Payment is due upon receipt of your statement. Your co -pay and any deductible are expected at the time of service. We accept Cash, Check and Credit Card. I authorize that payment of Medicaid, Medicare or other Commercial insurance company benefits made to Nahhas Dermatology at the Toledo Clinic for services provided. For cosmetic services not covered by health insurance, charges are payable on or before the day of service.

I understand that all outside laboratory testing will be billed from the specific laboratories to me and/or my insurance company. I accept payment responsibilities if my insurance denies payment. A copy of this authorization considered as valid as the original.

I acknowledge I have read this information thoroughly and understand this consent to treatment and patient financial responsibility form.

Signature: _____ Date: _____

Relationship to the patient (if other than patient) _____