

AS A COURTESY, OUR OFFICE WILL CALL TO REMIND YOU OF YOUR UPCOMING APPOINTMENTS. THERE WILL BE A CHARGE OF \$100.00 FOR MISSED APPOINTMENTS NOT CANCELLED AT LEAST 48 HOURS PRIOR TO SCHEDULED APPOINTMENT TIME. THANK YOU FOR YOUR UNDERSTANDING AND CONSIDERATION.

SIGNATURE: _____

DATE: _____

FINANCIAL AGREEMENTS

FOR PATIENTS WITH MEDICAL INSURANCE, THE DEDUCTIBLE AND CO-PAYMENT IS DUE AT THE TIME OF YOUR OFFICE VISIT. THE BALANCE REMAINING WILL BE BILLED TO YOU OR DEBITED FROM YOUR CREDIT CARD AFTER YOUR MEDICAL CLAIM HAS BEEN PROCESSED. WE ARE NO LONGER BILLING FOR LASER OR ACNE TREATMENTS TO ANY INSURANCE COMPANY. YOU MUST PRESENT YOUR INSURANCE CARD AT THE TIME OF YOUR FIRST VISIT. IF YOUR INSURANCE CARD IS NOT PRESENTED, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL OR YOU HAVE THE OPTION OF RESCHEDULING YOUR APPOINTMENT FOR A LATER DATE.

FOR COSMETIC PROCEDURES AND SKIN CARE PRODUCTS, PAYMENT IN FULL IS EXPECTED AT THE TIME OF EACH VISIT. SKIN CARE PRODUCTS ARE NON-REFUNDABLE. THANK YOU!

SIGNATURE: _____

DATE: _____

NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT RECEIPT

I ACKNOWLEDGE RECEIPT OF NISSAN PILEST, M.D. INC.'S NOTICE OF PRIVACY PRACTICES PAMPHLET.

SIGNATURE: _____

DATE: _____

ASSIGNMENT OF BENEFITS & MEDICAL RELEASE AUTHORIZATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY MEDICAL CLAIM AND ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO MY PHYSICIAN; NISSAN PILEST, M.D., INC.

SIGNATURE: _____

DATE: _____

A PHOTOSTAT COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

MEDICARE PATIENTS ONLY

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE DIRECTLY TO MY PHYSICIAN; NISSAN PILEST, M.D., INC. I ALSO AUTHORIZE MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY PORTION DETERMINED BY MEDICARE, AS "PATIENT RESPONSIBLE" AND ANY CHARGES NOT COVERED BY MEDICARE WILL BE MY RESPONSIBILITY.

SIGNATURE: _____

DATE: _____

THANK YOU FOR VISITING US TODAY!