KESSEL DERMATOLOGY
Daniel S. Kessel, MD PC

Patient Name: _____

Parent or Guardian (If not self)_____

Health Care Eligibility Waiver and Financial Responsibility

The patient (or patient's legal representative) hereby certifies that he/she is eligible for health plan benefits coverage and has chosen the health care provider with which he/she has made an appointment.

The patient (or patient's legal representative) understands that he/she is responsible for any copay and/or deductible and/or all needed referrals. Also, if the patient is found ineligible for coverage of plan benefits, he/she is financially responsible for all costs and expenses incurred during the delivery of health services and agrees to pay these charges to Kessel Dermatology accordingly.

_____ _____

Patient or Guardian Signature Date

Cancellation Policy / No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Therefore, if an appointment is not canceled at least 24 hours in advance you will be charged a $50 fee for office visit, $100 fee for surgery, and $150 fee for Moh's surgery; this will not be covered by your insurance company.

_____ _____

Patient or Guardian Signature Date