Anthony V. Benedetto, D.O., FACP
Ernest A. Benedetto, M.D.
Mohs Micrographic Surgery for Skin Cancer
Dermatologic Surgery

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STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: ________________________ Date of Birth:______________________

Benedetto Dermatology, PC, appreciates the confidence you have shown in choosing us for your health care needs and will offer the best quality medical care to all of our patients. As a courtesy to our patients we will verify your current insurance coverage and bill your insurance carrier on your behalf. However, due to the rising costs of medical coverage many insurance companies now have additional stipulations that may affect your coverage and it is ultimately the patient's responsibility to know their individual coverage and benefits. Furthermore, if your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage and policy period, you will be responsible for the remaining balance on your account. Thank you for your cooperation and understanding in this matter.

I have read the above policy regarding my financial responsibility to Benedetto Dermatology, PC, for providing medical services to me or the above named patient. I certify that the information provided by me is to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Benedetto Dermatology, PC - the full and entire amount of the bill incurred by me or the above named patient with the agreement that any amount remaining after such payment becomes the patient's responsibility. It is my understanding that Drs. Anthony and Ernest Benedetto are the owners and administrators of Benedetto Dermatology and the Dermatologic SurgiCenter.

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Signature of Patient/Parent or Guardian Date

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Name (please print)