Office Financial Policy

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. *As a courtesy to our patients, we will submit claims to your insurance carrier(s) if you provide us with all correct and pertinent information to process a claim at the time of your visit*. **You are responsible for all annual deductibles, copayments and/or coinsurance. Copayment is required before service is rendered. You are also responsible for all charges for non-covered and/or cosmetic services.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations; this is your responsibility. Credit on accounts will be extended for 60 days ***only*** if we have the necessary information to exercise our third-party rights. **If you cannot provide this information, your account is due at the time of service unless other payment arrangements have been made. A discount may be given on accounts without insurance (*self-pay)* but requires payment in full at the time of service.** Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt including, but not limited to, interest in the amount of 18%, per annum attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third-party debt collection agency.

Release of Information/Consent for Service

By receiving services, I agree to release claims-related information for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits, otherwise payable to me, directly to the doctor. I hereby give consent to this facility, medical staff, and employees to provide necessary health care services. I understand that there is some risk involved in any health care service such as scarring, recurrence, possible reactions to medication, etc. I accept such risk in the hope of obtaining beneficial results from such services. No guarantee for assurance has been given to me by anyone as to results that may be obtained.

Cosmetic Services

I understand that cosmetic services will not be covered by insurance and payment is expected at time of service. If my insurance denies a charge as being cosmetic, I will then be responsible for the denied cosmetic charge.

Medicare/Medicaid/Tricare Patient Certification

I certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me or my dependent to release any information needed to process a claim for this or any other related services to the Social Security Administration or its intermediaries, carriers, or to the state. I request that payment of authorized charges is made in my behalf directly to Rocky Mountain Dermatology for services provided to myself or my dependent.

Patient/Responsible Party Signature: ________________________________ Date: ____________

APPLIES TO SUBSEQUENT DATES OF SERVICE

My signature below signifies my understanding and willingness to comply with the above policies. I have also reviewed my Patient Information and certify that my address, phone number, insurance, HIPAA directives, and all other information is correct. I also certify that I have provided my current insurance card.

SIGNATURE	DATE	SIGNATURE	DATE