PORTLAND DERMATOLOGY CLINIC LLP

PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: _____ DOB: ___/___/___ Date ____/_____/_____

Receipt of Privacy Practices:
My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _____ **Date** _____/_____/_____

FINANCIAL POLICY:

Portland Dermatology Clinic (PDC) is pleased to participate in a large number of different insurance plans. While we are pleased to participate in these plans patient's individual coverage is not verified by our office staff prior to appointments. Patients should contact their insurance companies directly for any coverage questions they may have. Co-pays and deductibles usually apply to office visits and treatments performed at PDC. If the insurance company denies payment or only pays a portion of the medical bill, the patient will be responsible for payment of the remaining balance.

____Patients with insurance (not including Medicare):

Patients are asked to bring their current insurance identification card to each appointment. If your insurance information is not received within 1 business day of your appointment, the balance incurred from your visit will be your responsibility and your insurance will not be billed. Co-payments are due at time of service. Patients are responsible for paying insurance deductibles, co-insurance, and any services not covered by insurance.
For patients on insurance plans in which our doctors are not contracted, as a courtesy, we will submit a claim to your insurance company. A down payment of $216 is due at time of service. Any additional services will require a payment of 35% of the total bill at the time of service.

____Patients without insurance (Private Pay):

Payment is due in full at the time of service. Please note, if you have a procedure your specimen may be sent out for tissue processing which could prompt an additional bill from our preferred laboratory.

____Cosmetic Procedures:

Payment for any cosmetic procedure is due at time of service. Certain procedures require a prepayment to hold the appointment. This payment is kept as a deposit and will be applied to the consultation with the doctor.

Agreement:

I understand that if my account becomes delinquent, it may be assigned to a collection agency and a $25 late fee will be accessed. I have read and understand the Portland Dermatology Clinic Financial Policy. My signature below indicates that I accept this policy and agree to abide by the terms for my treatment at the Portland Dermatology Clinic.

Patient or Responsible Party Signature_____ Date _____/_____/_____

MEDICARE PATIENT'S SEE REVERSE SIDE

Medicare Subscribers

Medicare Payment Policy:

_____We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $162.00 deductible and paying for the 20% copayment. We do file with secondary / supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balanced billed.

Please sign so we may have your Medicare Authorization on file:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits applies.

Signature: _____ Date: _____/_____/_____

Please sign so we may have your Supplemental Authorization on file:
I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____/_____/_____

Note: If you have recently joined (or changed) to a Medicare Advantage plan, please let our staff know so we can update your records and advise you if we are participating providers.

Please present Medicare and secondary insurance card(s) and a photo ID to the receptionist so copies may be made.