Portland Dermatology Clinic, LLP

Privacy Practice & Financial Policy

Patient Name:_____ **Date of Birth:**_____

Receipt of Privacy Practice:
My signature below indicates that I have received or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices)

Patient or Responsible party Signature:_____ Date_____/_____/_____

Financial Policy:
Portland Dermatology Clinic (PDC) is pleased to participate with many insurance plans and networks. Patients should contact their insurance companies directly to check for PDC network participation and benefit information. Patients are responsible for paying for services rendered and not paid by insurance.

_____**Patients with insurance**:
Commercial Insurance:

- Patients are asked to bring a current copy of insurance and identification card(s) to each appointment.
- Copayments are due and collected at the time of service. We will submit a claim for medically necessary services to your insurance plan. You will be responsible and balance billed for any applicable deductible, co-insurance/cost share or non-covered services your insurance plan has allocated as your responsibility.
- If you do not provide current and/or active insurance information at the time of service you will be asked to pay for services in full. You have 1 business day to provide this information before you are balance billed for services rendered.

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Note: If you have recently joined or participate in a Medicare Advantage plan, please let our office staff know so we can update your records and advise you if we are participating providers**.**

_____ **Private Pay**:
Patients without insurance: Payment is due in full at the time of service. Please note, if you have a procedure your tissue may be sent to a pathologist/outside laboratory for further processing. Your billing information will be supplied to that provider and you will receive a separate statement from that provider of service.

_____ **Cosmetic Procedures**:
Payment is due at the time of service for any procedure not deemed medically necessary or cosmetic by our physicians and/or your insurance company. Certain procedures require prepayment to hold an appointment. This payment is kept as a deposit and will be applied to your future appointment.

_____**All Patients**
During the course of your medical care it may be necessary to consult or utilize other medical services (labs, hospital, pathologist), in these circumstances we will provide them with your insurance and billing information to charge for the services they render on your behalf. You will receive a separate statement from that provider.

Agreement:
I attest the information provided to the Portland Dermatology Clinic is correct and true to the best of my knowledge. I hereby assign benefits to Portland Dermatology Clinic, LLC and authorized them to furnish information regarding my medical conditions to my insurance carrier or its intermediaries. I understand that I am responsible for payment on any amount not paid by my insurance per plan provisions of my policy. Furthermore, I understand that if payment is returned due to insufficient funds or my account is turned over to a collection agency for non-payment, a $25 fee will be assessed. I have read and understand the financial policy and my signature indicates I accept this policy and agree to abide by the terms for my services provided at the Portland Dermatology Clinic.

Patient or Responsible party Signature:_____ Date_____/_____/_____