MID-COLUMBIA
DERMATOLOGY

Patient Policy

Patient Responsibility: Patients are responsible for all charges resulting from treatment provided by this clinic. As a service to you we bill most insurance carriers directly. However, primary responsibility for the account is yours. Payment is due at time of service, unless other financial arrangements are made. This includes deductibles, co-pays, and/or co-insurance. Established patients with a balance will be asked for payment at time of service.

I assign Mid-Columbia Dermatology all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days may be subject to fees and be turned over to a collection agency.

For cosmetic procedures and skin care products, payment in full is expected at the time of each visit.

Minors: Patient under 18 years of age will be responsibility of the custodial parent(s).

Referrals: If your insurance requires a referral for you primary care provider (PCP) to see a specialist, it is your responsibility to obtain a referral/authorization prior to your appointment.

Insurance Billing: We will, as a courtesy, bill your primary insurance carrier. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your new insurance information at your next visit. Charges owed due to claim rejection and/or non-response by the insurance company is the responsibility of the patient.

Medicare: Our providers are participating providers. I understand that I will be responsible for any portion determined by Medicare as "patient responsibility" and any charges not covered by Medicare will be my responsibility. Please provide staff with secondary insurance information if you have it.

Check Returns: It is our policy to charge all patients a $30.00 fee for returned checks.

Cancellation: A $30.00 fee will be charged for any appointment cancelled without 24 hours notice.

Laboratory: We send all biopsies and lab work to an outside lab. You will receive a separate bill from this company.

I am aware of the following potential complications as outlined for any procedure performed at Mid-Columbia Dermatology:
Bleeding, Nerve damage, Infection, Postoperative problems, Scarring, Pain

Authorization to Release Information: I have read and I accept this policy for my testing and/or treatment with Mid-Columbia Dermatology. The Notice of Privacy Practices for Mid-Columbia Dermatology is available at the clinic reception desk and I acknowledge I have seen a copy of the Notice of Privacy Practices.

I, or my appointed agent, have read, fully understand and agree to the above statements.

_____ _____ _____
Patient Name (print) Patient Signature Date

If the patient is under the age of 18, or otherwise unable to sign, complete the following:

Patient is _____ year(s) of age or is unable to sign because: _____

_____ _____ _____
Signature Relationship to Patient Date