**VALLEY DERMATOLOGY ASSOCIATES AND ESTHETICS**

**PAYMENT POLICY**

All accounts are due and payable in full within 60 days; if you need to set up a payment agreement, please contact our Billing Department. Regardless of your insurance, you are responsible for payment of all services rendered. As a courtesy to you, we will bill Primary and Secondary insurances. However, we are not contracted with all insurance carriers. Since most insurance carriers pay less than 100% of actual charges, a payment may be required at time of service unless other financial arrangements are made with the Billing Department. If you are without insurance coverage, prior to your appointment, you will meet with the Billing Office Representative to discuss payment options. The Billing Office can be reached at: 509-965-5586.

**Cancelation/No Show Policy**

As a courtesy, we attempt to contact patients to remind them of appointments; however, it is the responsibility of the patient to arrive for their appointment on time. Our goal is provide quality medical care in a timely manner. In order to do so, we have “no show” and cancelation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

**Cancelation of an Appointment:** In order to be respectful of the medical needs of all our patients please be courteous and call our office promptly if you are unable to keep your appointment. Late cancellations – Appointments canceled with less than 24 hour notice will be considered No Show.

If you cancel your appointment it could be 6-8 weeks before you can be scheduled back in the office.

**No Show Policy:** A “no show” is someone who misses an appointment without canceling 24 hours in advance. “No Show” appointments are subject to dismissal from our practice.

**Late Arrival to Appointment:** It will be up the Provider to see or reschedule anyone that shows up 15 minutes (or more) to an appointment.

**Related Fees:** A $50-$100 deposit is required on all cosmetic procedures scheduled. The deposit will be returned if canceled without 24 hours of the appointment; if canceled with less than 24 hours the deposit is forfeited.

* Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE COVERAGE & ASSIGNMENT OF INSURANCE PAYMENTS**

I authorize the release of information to my insurance company for processing claims. For all services I receive, I authorize and request my insurance company to make reimbursement payable on my behalf to Valley Dermatology Associates.

Insurance Authorizations: I understand that if my insurance requires a referral it is my responsibility to obtain the referral from my primary care provider. If there is not a current referral on file for any visit for which I am seen, I agree that the charges incurred will be billed to me privately instead of my insurance carrier.

* Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***See reverse side for Medicare Life Authorization***

**MEDICARE COVERAGE LIFETIME AUTHORIZATION**

1. The Patient, if physically and mentally competent, must sign on his/her own behalf. If the patient cannot sign, a representative payee as designated by the Social Security Administration or a legally appointed guardian may sign. The source of the signatory’s authority should be stated, i.e., Social Security-appointed Representative payee, court appointed-guardian, etc.
2. This form is used in lieu of the patient’s signature on the “Request for Payment” form, HCFA 1500, and is therefore an extension of that form anyone who misrepresents or falsifies essential information in making Medicare claims may, upon conviction by law, be subjected to fine and imprisonment under Federal Law.
3. This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for proper consideration of a claim. Please read and sign the following statement:

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 apply.

I request that payment of authorized MEDICARE benefits be made on my behalf to: Valley Dermatology Associates.

I authorize any holder of medical information about me to release to the CENTER FOR MEDICARE AND MEDICAID SERVICES, and its agents, any information needed to determine these benefits or the benefits payable for related services.

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**MEDICARE PATIENTS ONLY NEED TO COMPLETE THIS AREA**

YES NO

\_\_\_\_ \_\_\_\_ Have you recently joined a Medicare HMO? Which one?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ \_\_\_\_ Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?

\_\_\_\_ \_\_\_\_ Are you covered by an HMO/PPO which makes Medicare secondary?

\_\_\_\_ \_\_\_\_ Is this illness covered by the VA (Veteran’s Administration)?

\_\_\_\_ \_\_\_\_ Is this illness covered by the Federal Black Lung End Stage Renal Disease Program?

\_\_\_\_ \_\_\_\_ Is this illness due to an automobile accident?

\_\_\_\_ \_\_\_\_ Is this illness due to an injury at work?

\_\_\_\_ \_\_\_\_ Are you receiving Medicaid?

\_\_\_\_ \_\_\_\_ Do you have a Supplemental Insurance? Which one?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Signature as it appears on Medicare card Date*