

Island Dermatology, PLLC

Signature on File

Patient Name: _____ Today's Date
 ____/____/____

Patient's other family members:

Referred by: _____ Primary Care Physician:

In case of Emergency, who should be notified? _____ Phone: (_____) _____

<p>RELEASE OF INFORMATION: I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payments of medical benefits to the physician.</p>	<u>Patient Initials</u>
<p>RECEIPT OF NOTICE OF PRIVACY PRACTICES: My signature below indicates that I have and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices)</p>	<u>Patient Initials</u>
<p>GENERAL CONSENT FOR PHOTOGRAPHS: I authorize the clinic to use photographs, videotapes, digital, or other images as recorded documentation of my care. The Practice will retain the ownership rights to these photographs, videotapes, digital, or other images, but I can view them or obtain copies. All images will be stored in a secure manner that will protect patient privacy and they will be kept for the time period required by law or outlined in the Practice's policy. Images that identify a patient will only be released and/or used outside the institution upon written authorization from the patient or a legal representative.</p>	<u>Patient Initials</u>

Please read the following carefully before signing

I authorize treatment of the person named above and agree to pay fees for such treatment. I hereby authorize the clinic to receive all benefits to which I or my dependents are entitled to under my health insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. The undersigned agrees that whether he/she signs as an agent that he/she is obligated to pay for the account. Should the account exceed an amount that the undersigned is able to pay, agreed upon payments by the undersigned and the clinic can be established with a 1% interest per month – 12% annually - (RCW 19.52) on the unpaid balance. Should the account be referred for collections, the undersigned, or their agent will be responsible for payment of interest on the unpaid balance at 1% per month from 31 days following the first statement date as well as collection fees, reasonable attorney fees, and court costs. I have also been informed of the \$30.00 fee (per RCW 62A.3-515 & 520) on checks returned NSF.

Patient or Responsible Party Signature: _____

Commercial Patients: Patients who are covered by private, commercial plans that are not contracted with Island Dermatology will be required to pay 35% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.
HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, co-payments and charges for any non-covered, cosmetic services.

MEDICARE PATIENTS

ONLY

Medicare: We are participating providers with the Medicare program. We will accept assignment on all claims. Patients

are responsible for meeting their annual deductible and paying for the 20% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed for the balance.

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

Patient or Responsible Party Signature: _____

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 the 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 Noridian Medicare and the 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.

Signature as it appears on Medicare Card: _____

If you have a supplemental policy and it is a **MEDIGAP** policy that your Medicare Carrier automatically bills for you we are required to keep a separate signature on file. I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorized 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 as it appears on MEDIGAP Card: _____