THE FOLLOWING ARE INTERNAL POLICIES SET IN PLACE BY THE ADMINISTRATION OF DERMATOLOGY ASSOCIATES OF SOUTHWEST WASHINGTON. SIGNATURE IS REQUIRED BEFORE SERVICES CAN BE PROVIDED

PATIENT COMMUNICATION

I understand that messages or confidential messages may be left on my voicemail or answering machine at the preferred number(s) you have provided to Dermatology Associates of Southwest Washington. We may also communicate with you via e-mail, text message, or letter to your home address provided as long as such method complies with applicable HIPAA communication standards.

ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY

I do, hereby authorize payment of my insurance benefits, including authorized Medicare benefits, basic and major medical for the services I receive, to be made directly to Dermatology Associates of Southwest Washington.

CONSENT FOR MEDICAL SERVICES

I authorize Dermatology Associates of Southwest Washington to render treatment to me or my dependents for dermatological care or medical procedures as deemed medically necessary for treatment as indicated.

REFERRALS/AUTHORIZATIONS

I understand that if my insurance requires a referral or an authorization, I am responsible for obtaining the referral prior to my visit. If I do not have a referral or authorization at the time of my visit, I may be rescheduled or sign a waiver of financial responsibility. In such case I understand that full payment will be required at the time of service.

MEDICARE PATIENTS

I understand that Medicare may not cover some of the services that my doctor recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

MINOR PATIENTS

All minors are required to have a parent/legal guardian present with them for each appointment. By law, we are required to have consent from a legal guardian to provide treatment to a minor. If a parent or guardian is unable to attend an appointment with the minor, then a signed and dated authorization to treat a minor is required prior to the appointment. If a minor comes to the office unattended and we do not have a signed and dated authorization from the parent/legal guardian for a specific day(s) of treatment, we will be unable to see the patient at that time, and the appointment will have to be rescheduled.

FINANCIAL RESPONSIBILITY

I understand that although Dermatology Associates of Southwest Washington will file a claim to my insurance plan(s), I am expected to pay my copayment, coinsurance, deductible and non-covered services amount at the time services are rendered. I agree to pay a $25 fee if I fail to pay my copay at the time of check-in. I acknowledge that Dermatology Associates of Southwest Washington does not guarantee payment of my claim by my insurance plan and that it is my responsibility to know the provisions of my insurance. Not all procedures are deemed “Medically Necessary” by insurance carriers and can be considered cosmetic. For example-Skin tag removal or correction of dark spots may not be a covered service. I understand that I would be responsible for payment of such services. I am ultimately responsible for any unpaid balance or non-covered service.

I agree to pay all costs of collecting, securing or attempting to collect or secure payment, including reasonable attorney fees or collection agency fees. If it becomes necessary to turn your account over to an outside collection agency, a non-negotiable fee of $75.00 will be owed in addition to the remaining balance. Patients who are sent to collections will be discharged from the practice.

I also understand that any prior unpaid balances on my account must be paid in full before being seen by a provider. If my prior balance cannot be paid in full, I will speak with a Billing Specialist at Dermatology Associates of Southwest Washington to make a payment arrangement before services can be rendered.

I also understand that if Dermatology Associates of Southwest Washington does not participate with my insurance plan that I will be expected to pay in full for my services. And it is my responsibility to know if Dermatology Associates of Southwest Washington is in network with my insurance plan.

I understand that payments to Dermatology Associates of Southwest Washington can be made by cash, checks and all major credit cards. I also acknowledge that returned checks will be subject to a non-sufficient fund fee of $35.00.

SELF PAY PATIENTS (PATIENTS WITHOUT INSURANCE)

I understand I should be prepared to pay in full at the time of each visit. Since Dermatology Associates of Southwest Washington is unable to predict what services will be performed prior to your appointment, the practice requires that you make a down payment of $150.00 at check-in. At the end of your appointment, your final fee will be determined and your $150.00 down payment will be applied. Any additional monies owed will be collected or refunded to you at that time.

COSMETIC SERVICES

Cosmetic services are not a covered benefit under insurance plans. I understand that to make an appointment for cosmetic services, I will be expected to pay in full at the time services are rendered.

PATIENT RESPONSIBILITY

I understand that due to Federal (red flag) rules, Dermatology Associates of Southwest Washington is prevented from filing to my insurance without proof of identification. I will be expected to present a photo ID and insurance card(s) at every office visit. I will also update any changes to my addresses, telephone numbers and insurance if they have changed since my last visit and I understand that I will be asked to update my demographics and signatures annually.

MISSED APPOINTMENTS/ LATE ARRIVALS

I understand that if I arrive late for a scheduled appointment, I may be asked to reschedule or wait for another open appointment time on that day's schedule.

It is my responsibility to notify Dermatology Associates of Southwest Washington at least 48 hours prior to my appointment if I am unable to keep the appointment. I acknowledge that if I miss appointments without sufficient notification that I may be charged a $45 fee or I may be dismissed from the practice for non-compliance.

PRIVACY POLICY NOTICES

I have been offered a copy of Dermatology Associates of Southwest Washington's Notice of Privacy Policies that details how my personal health information may be used, disclosed and my rights as permitted by federal law. As well I understand that this notice is posted for my benefit in the reception areas and on the website of Dermatology Associates of Southwest Washington.

ePRESCRIBING CONSENT

I acknowledge that Dermatology Associates of Southwest Washington utilizes electronic health records and will transmit my prescriptions electronically as permitted to the pharmacy that I designate as my pharmacy provider. To enable electronic prescriptions to my pharmacy, I grant Dermatology Associates of Southwest Washington my permission to access my medication history to view current and past prescription information.

PRESCRIPTION REFILLS

Please plan ahead for prescription refills. We ask that you contact your pharmacy three (3) to five (5) days prior to needing a refill. If you are out of refills, the pharmacy will contact our office for physician approval. Please note, we will only refill prescriptions during our normal business hours. We will not refill prescriptions if you are outside the recommended follow-up window. As a general rule, no refills will be given for patients who have not been seen in the practice during the past twelve months for that specific prescription.

LAB SERVICES

If you have labs or tests performed at our office, please make sure to call if you have not heard from us within 7-10 days for your results. Please do not assume that your results are negative if you have not heard from us; it is possible that we have not received your results, or that we were unable to get into contact with you.

I am aware that my laboratory/pathology services are billed separately from Dermatology Associates of Southwest Washington. I will receive a separate statement from another lab or pathologist. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason. Charges for the lab tests are billed separately and not included in the charges for my office visit.

In addition, it is my responsibility to contact my insurance plan to determine what laboratory is in network.

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Patient Printed Name

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Patient/Guardian Signature Date: