PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Pharmacy of choice: _____ Primary Care Physician: _____

Emergency Contact: _____ / _____ Phone# _____
Relationship to Patient

Do we have your permission to:
Leave a message on your answering machine at home? Yes ☐ No ☐
Leave a message at your employment? Yes ☐ No ☐
May we discuss your medical condition with a member of your household? Yes ☐ No ☐
If yes, with whom? _____ Relationship: _____

I authorize the release of medical information to my primary care or referring physician, to pathologists/labs/consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. Please note: if your visit requires any pathology, laboratory tests or a consultant's review you will be charged a fee from that said office.

_____ _____
Patient or Responsible Party Signature Date

PAYMENT POLICY:

PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE. We participate with Alaska Medicaid and Medicare Part B ONLY. Please have your insurance card(s) and picture I.D. available at the time of service. If you wish to submit a claim to your insurance company for reimbursement, we will happily give you an invoice for that purpose. We accept Visa and MasterCard for your convenience.

Medicare: We are a participating provider of the Medicare program. We will accept assignment on all claims. We do file with secondary carriers, if you have any additional carriers you must submit a claim for reimbursement.

Medicaid: We are a participating provider of the Alaska Medicaid program. However, your **three-dollar co-pay shall be collected** and paid in full when you check in for your appointment. (Exemptions: children under the age of 18, expecting mothers, women that are breast feeding up to three months post delivery.)

Private/Commercial Insurance: The Dermatology and Skin Cancer Clinic of Alaska, PC is not contracted with **any** commercial or private healthcare company. Payment is expected from you at the time services are rendered.

It is the sole responsibility of the patient to be informed as to their insurance policy coverage and benefits before their office visit.

Patients who are covered by a private or commercial plan will be responsible for paying their deductible, co-payment and charges for any non-covered services, on the date of service. The entire unpaid balance left after payment from your insurance company will be billed to you regardless of the benefits and payment policies of your carrier.

I have read and agree to the above payment policy.

_____ _____
Patient or Responsible Party Signature Date

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file. This authorizes 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 to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Signature as it appears on Medicare Card Date

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare automatically "crosses over", 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 authorize 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 Medicare Card Date