THE DERMATOLOGY AND SKIN CANCER CLINIC OF ALASKA
180 E. Beluga Ave. Soldotna, Alaska 99669
Mathew M. Cannava, M.D.

PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

PAYMENT POLICY: *PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE*. **We participate with Alaska Medicaid and Medicare Part B ONLY**. If you wish to submit a claim to your insurance company for reimbursement, we will happily provide you an invoice for that purpose.

****It is the sole responsibility of the patient to be informed of their insurance policy coverage, benefits, and/or obtain an insurance authorization *before* their office visit.****

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.

Private/Commercial Insurance recipients: The Dermatology and Skin Cancer Clinic of Alaska, P.C. is not contracted with any commercial or private healthcare companies. Patients are responsible for paying their deductible, co-payment, and charges for any non-covered services at the time of service.

- **Blue Cross, Cigna, United Healthcare, and Tricare recipients are expected to pay 100% at the time of service.**

Medicaid recipients: 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 out after your appointment. (Exemptions: children under the age of 18, expecting mothers, women that are breastfeeding up to three months post delivery.)

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

I have read and agree to the above payment policy.

➔ 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 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.

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 are made on my behalf for any services furnished to me. I authorize any holder of medical information to release any information needed to determine these benefits or the benefits payable for related services.

I have read and agree to the applicable Medicare and MEDIGAP statements above.

➔ Signature: _____Date: _____