DERM ONE
Dermatology Care

Because there are so many different insurance plans, all benefits are not alike and you can no longer assume that all medical services will have a covered benefit. Because we are considered specialists, your plan may now require that you first seek treatment from or be referred to us by your primary care physician or family physician. In addition, recommended treatment plans and surgical procedures may require prior authorization. If your insurance provider determines that a service is not covered, you will be responsible for payment in full. There are numerous rules that could apply to your current coverage. These rules are dictated by your insurance provider.

Each person covered under a group plan should receive a member ID card. However, possession of an ID card does not guarantee coverage or payment for services rendered. Patients will now be required to present this card at each visit to assure coverage and benefits have not changed since last visit. This will aid our staff in verifying eligibility and benefits and filing claims on your behalf.

It is to your benefit to know and understand your insurance coverage. Failure to do so could result in your financial loss through reduced benefits or denied payments of your claims. We will bill your insurance company. This office cannot accept responsibility for collections and your insurance claim or negotiating a settlement on a disputed claim.

ALL PATIENTS ARE ASKED TO PAY THE CO-PAY AMOUNT THAT IS LISTED OR REQUIRED ON THEIR INSURANCE CARD. IF YOUR INSURANCE CARD DOES NOT STATE A CERTAIN CO-PAY AMOUNT, YOU ARE ASKED TO PAY 20% OF THE CHARGE AT THE TIME OF SERVICE, OR THE FULL AMOUNT OF THE CHARGE IF YOU HAVE NOT MET YOUR REQUIRED DEDUCTIBLE.

AUTHORIZATION TO BILL AND RECEIVE A PAYMENT AND RELEASE MEDICAL INFORMATION TO YOUR INSURANCE COMPANY

I request that payment of authorized Medicare or insurance benefits be made directly to the provider for any service provided to me. I authorize the release of any necessary medical and related information to any insurance provider to determine payment and/or process claims.

_____ _____

Signature of Patient or Responsible Party Date

SELF PAY PATIENT

I understand that if I have no medical insurance, I will be held responsible for any charges services rendered by Derm One, PLLC.

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Signature of Patient or Responsible Party Date