DERMATOLOGY ASSOCIATES, P.A.

INSURANCE AND PAYMENT POLICIES

Our office participates with most major insurance plans with the exception of the Blue Cross Blue Shield " **BLUE VALUE PLAN**" "We do accept and file all other Blue Cross Plans." If you are a Blue Cross Blue Shield member please check your card and if it is the Blue Value Plan you will be considered a SELF PAY PATIENT and payment for your services will be due at the time of your visit.

Self Pay Patients- Self pay patients will be required to pay $80.00 at check-in and the remaining balance when you check-out the same day.

United Healthcare Insurance **COMPASS PLAN**- If you have the United Healthcare COMPASS PLAN, you must obtain an authorization prior to your appointment. If the authorization is not obtained prior to your appointment we will have to reschedule your appointment until authorization is obtained.

Veterans Administration Insurance- If you have VA Insurance you must have an authorization to be seen in our office. Please contact your local Veterans Administration to obtain your authorization. If an authorization is not obtained prior to your visit we will have to reschedule your appointment.

Tricare Prime Insurance- If you have Tricare Prime Insurance you must have an authorization to be seen in our office. Please contact your Primary Care Physician to obtain your authorization. If an authorization is not obtained prior to your visit we will have to reschedule your appointment.

PLEASE NOTE: IT IS THE PATIENTS RESPONSIBILITY TO OBTAIN ALL AUTHORIZATIONS.

Co-pays - All Co-pays will be expected to be paid at time of service.

Thank you again, for choosing our practice to help with your skin needs and for your cooperation with our office policies.

Dermatology Associates, P.A.

INSURANCE INFORMATION

If under 18, Name of person responsible for bill ____ Relationship to patient ______________________

Address of responsible party ____ Phone (______) ____________________________

Primary Insurance:

Name of Insurance Co: ____

Policy Holder's Name: ____

Policy Holder'S SS#: ____

Policy Holder's DOB: ____

Policy Holder's Employer: _____________________________________

Relationship to Patient: _______________________________________

Secondary Insurance:

Name of Insurance Co: ____

Policy Holder's Name: ____

Policy Holder's SS#: ____

Policy Holder'S DOB: ____

Policy Holder's Employer: _____________________________________

Relationship to Patient: _______________________________________

I authorize the release of any medical or other information necessary to process insurance claims. Any authorization needed for my insurance is my responsibility at time of service and I will be responsible for payment if authorization is not obtained. I also request payment of insurance/ government benefits to myself or the party who accepts assignment.

Signature: ____ Date: ____

******* PLEASE SHOW INSURANCE CARDS ********

Please do not sign below until you arrive for your appointment.
At that time we will supply you with a copy of our HIPPA and Pathology Policies to review.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Name: ____ Birthday: ____

Signature: ____ Date: ____

Please list any family members or patient representatives you would like to share your Protected Medical Information:

Let us know if you will allow us to leave messages on your home answering machine regarding your care/pathology reports/referral appointments:

Circle one: Yes, it is okay to leave a message No, do not leave messages

PATHOLOGY BILLING POLICY ACKNOWLEDGEMENT

I have read and understand the Pathology Billing Policy.

Signature: ____ Date: ____