CAROLINA DERMATOLOGY
OF GREENVILLE

Patient Name: _____

Date of Birth: _____

PRACTICE FINANCIAL POLICY

Please review and acknowledge below.

- Co-payments for office services are required at the time you check-in.
- As a courtesy, we will process and file your insurance claims for services at no cost to you.
- For services that are covered by insurance, the practice requires payment of approximately 20% of the total estimated charges or the co-payment specified by your insurance.
- For services that are <u>not</u> covered by insurance, the practice requires payment of 100% of total charges unless payment arrangements have been worked out.
- Returned checks are subject to a handling fee of $20.00. In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.

You must realize that:

1. Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

2. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We will allow you 90 days to pay any balance remaining after insurance payment. After that time, your account will accrue interest at the rate of Prime plus 2%. Our staff will make arrangements for you to make monthly payments over an approved term. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to help you.

PLEASE READ THE ABOVE CAREFULLY <u>BEFORE</u> SIGNING. By signing below, I acknowledge that I have read and understand this policy.

Signature:_____ Date:_____

(Patient and/or Responsible Party)

Carolina Dermatology, PA
920 Woodruff Road
Greenville, SC 29607
Phone: 864-233-6338
www.carolinaderm.com

CAROLINA DERMATOLOGY
OF GREENVILLE

Patient Name: _____

Date of Birth: _____

INSURANCE INFORMATION RELEASE CONSENT FORM

MEDICARE AUTHORIZATION

_____ _____
Initials Date

I authorize the holder of medical or other information to release to the Social Security Administration and Health Care Financing Administration, its intermediaries or carrier, any information needed to file a Medicare claim. I permit a copy of this authorization form to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. DEDUCTIBLE AND CO-INSURANCE (20% IF NO SUPPLEMENT) IS DUE AND EXPECTED AT THE TIME OF SERVICE.

TRICARE INSURANCE

If you have Tricare or Tricare Prime, please READ CAREFULLY:

_____ _____
Initials Date

We are currently certified providers with Tricare and in Network with Tricare Prime; however, Tricare Prime (Active Duty members) does require a referral and/or prior authorization for which the patient is responsible for acquiring from their primary care physician.

I authorize the release of medical information for services rendered to my insurance company, and also authorize payment of medical benefits to the physician. I understand that I am responsible for any amount not covered by insurance. I also consent to the taking of photographs for medical, teaching purposes and office use.

_____ _____
PATIENT SIGNATURE DATE

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

If you are 18 years of age or older; we must have your permission to discuss your treatment, medical, or financial information, etc. with anyone other than yourself. If a person's name is not listed on the consent form, we cannot discuss your information with them.

*****PLEASE SIGN IN ONLY ONE OF THE AREAS BELOW*****

I hereby give my consent for Carolina Dermatology, PA and staff to review or discuss my medical treatment, lab results, pathology reports, and/or financial information with the following person(s), other than myself. I understand that I must submit a written request to amend this list.

1. _____ Relationship: _____
   (FIRST & LAST NAME) (Date of Birth)

2. _____ Relationship: _____
   (FIRST & LAST NAME) (Date of Birth)

3. _____ Relationship: _____
   (FIRST & LAST NAME) (Date of Birth)

Signature: _____ Date:_____

OR

If there is no one that you wish your information to be released to, other than yourself, please sign below:

DO NOT RELEASE ANY INFORMATION ABOUT MY MEDICAL RECORDS OR FINANCIAL INFORMATION TO ANYONE OTHER THAN MYSELF.

Signature: _____ Date:_____

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