Willamette Dermatology, PC

Credit Policy

Patient Responsibility: Patients are responsible for all charges resulting from treatment provided by **Clinic/Physician**. As a service to you, we bill most insurance carriers directly. However, primary responsibility for the account is yours. Payment is due within 30 days of the first billing, unless other financial arrangements are made. Established patients with a delinquent balance may be asked for payment at time of service.

- Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s).

Referrals: If your insurance requires a referral, from your Primary Care Provider (PCP), to see a specialist, it is your responsibility to obtain a referral/authorization prior to your appointment.

- A phone will be provided for your call. Please get the name of the person who authorizes your visit.

Insurance Billings: We will, as a courtesy, bill your primary insurance carrier. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your new insurance information at your next visit.

Medicare: Our physicians are participating providers. Although we bill Medicare as your primary insurer, you may be responsible for billing your supplement insurance. Note: Medicare may be able to bill your supplemental insurance, please contact them at 1-800-633-4227.

Oregon Welfare & Oregon Health Plan: Please bring your current medical card with you to each appointment. If you are restricted to a primary care physician by Oregon's Medical Assistance Program or Washington's Department of Social and Health Services, you must obtain a referral to the specialist by them.

Check Returned: It is our office policy to charge all patients a $25.00 fee for checks that are returned.

Authorization to Release Information:

I have read and I accept this policy for my Testing and/or treatment with Willamette Dermatology PC. In obtaining payment for services, I authorize my healthcare provider, Willamette Dermatology PC, to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including my insurance companies and their representatives, and my employer or union if they are involved in processing the claim.

If I have been referred by, or am being referred to, another healthcare provider, I authorize Willamette Dermatology P.C. to release my clinical information to this provider for continuing care.

I also assign Willamette Dermatology P.C. all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days will be subject to a processing fee.

I, OR MY APPOINTED AGENT, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS. I MAY ASK FOR A COPY OF THIS INFORMATION FOR MY RECORDS.

_____ _____ _____

Patient Name (print) Patient's Signature Date

IF PATIENT IS UNDER THE AGE OF 15 YEARS, OR IS OTHERWISE UNABLE TO SIGN, COMPLETE THE FOLLOWING

Patient is _____ year(s) of age or is unable to sign because: _____

_____ _____ _____

Signature Relationship to Patient Date

Sign Below if Disclosure of Information is not authorized:

Therefore, I agree to pay for costs of all treatment and services personally.

_____ _____ _____ _____

Signature of Guarantor Date Signature of Patient Date