

**Medicare Financial Policy**

**PAYMENT IS EXPECTED AT THE TIME OF SERVICE. IF YOU ARE UNABLE TO PAY PRIOR ARRANGEMENTS MUST BE MADE BEFORE SEENG THE DOCTOR**

For your convenience we accept cash, check, American Express, Discover, MasterCard and Visa.  
**There is a \$25.00 charge for a returned check.**

**Regarding Insurances with which we participate:** Blue Ridge Dermatology Associates, P.A. does participate with Medicare and many Medicare replacement plans and will file a claim for you. **You are responsible for any deductible, co-insurance and/or co-pay at the time of service.** If you have secondary coverage with an authorized Medigap carrier, the office will bill your secondary carrier.

**Regarding ANY INSURANCE POLICIES requiring referrals:** Obtaining the referral for the correct dermatological problem is the patient’s responsibility. **If a referral is not obtained** for the problem you wish to have addressed, **the total cost of the visit is due at the time of service.**

**Regarding non-covered services:** Services which your insurance company determines are not medically necessary will **not** be reimbursed by your insurance company. Examples of such services are removal of skin tags, normal moles and benign Keratosis. By law, we are required to have you sign a waiver acknowledging your financial responsibility for treatment of these conditions when these occasions arise. **Payment in full is due at the time of service.**

**MISSED APPOINTMENTS OR LATE CANCELLATIONS:**

**Please call at least 1 business day prior to your scheduled appointment to cancel or reschedule. This helps us accommodate other patients. Please be aware that scheduled appointments cancelled less than 1 business day prior to the designated time, or failure to keep a scheduled appointment, may risk a charge of a \$50 missed appointment fee (\$100 for surgery or 50% of physician cosmetic procedure fee).**

**Assignment of Benefits:** I hereby authorize and direct my insurance carrier (s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to Blue Ridge Dermatology Associates, P.A. for services provided to myself and/or my dependents. I understand I am responsible for any amount not covered by insurance as designated by my insurance company and Blue Ridge Dermatology Associates, P.A.

**Authorization to Release Information:** I hereby authorize Blue Ridge Dermatology Associates, P.A. to: (1) release any information necessary to insurance carriers regarding my diagnoses and treatments; (2) process insurance claims. This order will remain in effect until revoked by me in writing. I have sought medical services from Blue Ridge Dermatology Associates, P.A. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for all charges incurred during the treatment authorized.

**Your signature below indicates that you understand and accept this policy.**

**Signature of patient (legal guardian or power of attorney)**

**Date**

**Please answer the questions below by circling the appropriate answer:**

- NO      YES      Are you covered by a Medicare HMO plan?  
If yes, identify: \_\_\_\_\_
- NO      YES      Do you work in a company which has more than 20 employees and have insurance coverage through that job?  
If yes, Employer’s Name: \_\_\_\_\_
- NO      YES      Does your spouse work in a company which has more than 20 employees and provides insurance coverage for you?  
If yes, Spouse’s Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Employers Name: \_\_\_\_\_
- NO      YES      Are you receiving Medicaid?
- NO      YES      Are you a resident of a skilled nursing facility or nursing home?