REFERRAL INFORMATION
PATIENT FINANCIAL POLICY
SIGNATURE ON FILE

Patient's Name: _____ Date: _____
Other Family members that are patients: _____
Referred by: _____ Primary Care Physician: _____
Pharmacy of Choice: _____ Telephone: _____

RELEASE OF INFORMATION

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or responsible party: _____ Date: _____
SIGNATURE

PAYMENT POLICY

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

I authorize Bay Pointe Dermatology to charge my credit card for any co-insurance, deductible, co-payment, or procedures not covered by my insurance company. Bay Pointe Dermatology will provide me with a copy of my explanation of benefits and a receipt of the total charge to my card.

Type of Card: _____ Credit Card #_____ Exp: _____
Security code: _____ Signature authorization: _____ Date: _____
Patient or responsible party: _____ Date: _____
SIGNATURE

MEDICARE PATIENTS ONLY

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy if this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.
Signature as appears on Medicare Card_____ Date: _____

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information need to determine these benefits or the benefits payable for related services.
Signature as it appears on Medigap Card_____Date: _____