SKIN SURGERY CENTER
SKIN CANCER SPECIALISTS

Contact Consent and Financial Policy

Patient Name: _____ Patient DOB: _____/_____/_____

AUTHORIZATION TO LEAVE PERSONAL MEDICAL INFORMATION BY ALTERNATIVE MEANS – CHECK ALL THAT APPLY:

❑ May send personal medical information via an **e-mail message** to the address provided on my Registration Form. I understand that e-mail may not be a secure means of communication.	
❑ May leave a detailed message on voicemail at the **the following** phone number(s) provided on my Registration Form: ❑ Home ❑ Work ❑ Cell	
❑ May leave a detailed message at a different location, with a spouse/partner or with another family member:	Description: Phone Number: ( )

FINANCIAL POLICY: We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of: co-payments and charges for non-covered or cosmetic services. You will be asked to sign an Advanced Beneficiary Notice of Liability Form in the event that a service is provided which may not be covered by Medicare.

If we participate (are contracted) with a commercial insurance plan under which you are covered we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of: co-payments and charges for non-covered or cosmetic services. In the event that you, as the patient, or we, as the physicians, are not aware of a charge that is not covered by your plan, you will be billed for the balance after we obtain a denial from your insurance carrier.

For non-Medicare patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following: You may be asked to prepay the entire bill. Any amount not paid by your insurance company will be billed to you. If we are not contracted with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. Any remaining balance will be due with your monthly statement.

Some surgical procedures performed at the Skin Surgery Center are performed in our Ambulatory Surgery Center. You may be charged a facility fee in addition to the fee for your doctor's professional services. The Ambulatory Surgery Center is part of the Skin Surgery Center, P.S. which is owned by Dr. Peter B. Odland and Dr. Annalisa K. Gorman.

Please be mindful that there may be charges for services in addition to your visit with Skin Surgery Center. These charges may include outside laboratory service fees from LabCorp or NW Dermatopathology for slides, cultures and/or blood work.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Insurance coverage is NOT a guarantee of payment for services provided by my healthcare provider including preventive, routine screening, vaccinations, or procedures considered cosmetic in nature.

It is my responsibility to understand my insurance benefits.

It is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance. Co-payments mandated by my insurance company may not be printed on my insurance card. I understand the Co-payments are due at the time of service. It is my responsibility to notify the receptionist upon arrival that a co-payment is due.

I have been informed that payment is due upon the receipt of my monthly statement.

Should I have no insurance I understand that 50% is due at the time of service with the remaining balance due within 30 days.

Our billing office phone number is (206) 431-0138; please feel free to call this number should you have questions.

CANCELLATION POLICY: We ask for 2 days notice for all reschedules and cancellations of appointments. This courtesy allows our office to schedule another patient in your place. If an emergency arises, please give as much notice as possible. Failure to show up to a scheduled appointment without 48 hours notice will be subjected to a fee.

LATE POLICY: When a patient is more than 10 minutes late, we reserve the right to shorten or reschedule the appointment.

RETURNED CHECK POLICY: Returned checks are subject to a fee of $30.00.

Signature: _____ Today's Date: _____/_____/_____
(Patient or Responsible Party)