

NORTH IDAHO DERMATOLOGY

2288 Merritt Creek Loop ~ Coeur d'Alene, ID 83814

PH: (208)665-7546 / FAX: (208)667-4607

Website: niderm.com

Welcome to our office. Please read this information about our financial and billing policies.

If you DO NOT have insurance:

- ➔ **You must pay at the time of service or make prior arrangements with our billing staff**
- ➔ We accept cash, personal checks, MasterCard, Visa, American Express, and Discover Card

If you have insurance:

- ➔ As a courtesy we will file claims for you
- ➔ We will need your current insurance card and policy holder information
- ➔ You will need to authorize payment directly to us
- ➔ **If your insurance requires a co-payment, it is due at the time of service**
- ➔ You may be billed separately for Lab services
- ➔ Balance on your account will be due upon receipt of your monthly statement
- ➔ Even if you have insurance, **payment to us is your responsibility**
- ➔ Accounts not paid in full within 90 days are considered past due
- ➔ If you cannot make regular payments, please contact us
- ➔ Many insurance plans may require you to have: specific doctors, pre-certifications, and/or referrals. You are responsible to know the details for your insurance plan.

Minors:

- ➔ **Parent(s) or legal guardian must accompany a minor and are responsible for payments**
- ➔ In case of divorce, the Custodial Parents are responsible for all payments
- ➔ We will not be involved in disagreements between the parties in a divorce situation.

***There is a \$25.00 charge for each returned check.**

*If you have any questions about this information, please call (208) 665-7546

"I verify the accuracy of the billing information, and I authorize the release of any medical information necessary to process my medical claims."

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, North Idaho Dermatology, and medical providers employed with the same, may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to North Idaho Dermatology's Notice of Privacy for a more complete description of such uses and disclosures.

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered.

Patient Name (Please Print)

Date

Patient or Authorized Signature

Relationship to Patient

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Medicare Patients - Medicare Claim Release

**Please present your insurance cards to the receptionist.
We will scan your card(s) and return them to you promptly.**

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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 of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.

Signature as it appears on MEDICARE CARD

Date

If you have a supplemental policy to which your Medicare Carrier automatically “crosses over,” we are required to keep a separate signature on file:

I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

Signature for SUPPLEMENTAL card

Date