KENTUCKY DERMATOLOGY CLINIC
120 State Avenue, Glasgow, KY 42141
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Assignment of Benefits
Statement of Financial Policy

Patient name: ___________________________
Account number: ________________________

PLEASE READ THE FOLLOWING CAREFULLY. WE ARE HAPPY TO ANSWER ANY QUESTIONS THAT YOU MAY HAVE.

I. ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION, AND AGREEMENT FOR PAYMENT

I authorize direct payment to the Kentucky Dermatology Clinic ("Clinic") of benefits provided under any health care plan or medical expenses policy due to me or payable on behalf of the above patient.

I further authorize the Clinic to release any information required by any third-party payor regarding any claim for payment. I permit a copy of this authorization to be used instead of the original. Furthermore, I understand that this document as well as my signature may be stored as an electronic image.

I agree to pay for all medical expenses incurred relating to the treatment of the above patient. I acknowledge that all medical expenses not paid by third-party payor(s) are my responsibility and I agree to pay for same upon demand.

Applicable to Medicare patients:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I also request payment of any government benefits

payable on my behalf (or on behalf of the patient above) be paid to the Clinic under an assignment of benefits.

The Kentucky Dermatology Clinic participates in the Medicare program. This means that the Clinic receives Medicare's allowed amount for services covered by Medicare. Medicare will pay the Clinic 80% of the allowed amount, less any deductible amount for which the patient is responsible. Patients are responsible for the remaining 20%. Patients with secondary insurance are responsible for ensuring that the Clinic has complete information on all insurance coverage.

II. STATEMENT OF FINANCIAL POLICY

We will bill your insurance directly and receive payment directly from them. The filing of insurance claims is a courtesy extended to you. Our relationship is with you, the patient, not the insurance carrier. All charges are your responsibility from the date of the service rendered. The Clinic will not enter into any dispute with an insurance carrier regarding a claim that is the responsibility and obligation of the patient.

Co-payments and unmet deductibles are due at the time of service. The Clinic accepts payment by cash, personal checks, debit cards, as well as Visa, MasterCard, and Discover credit cards. Coinsurance amounts are due upon receipt of a Clinic statement indicating a patient due amount. In order to ensure the financial viability of the clinic, patients who do not pay co-payments at the time of service will be charged a monthly statement fee of $10.00. Patients with outstanding balances must make payment arrangements prior to being seen for non-urgent care. (This does not apply to follow-up appointments where the insurance carrier has not yet reimbursed us for a prior visit.)

Please bring your most current insurance card(s) each time you seek services at the Clinic. If you do not present your insurance card(s) at registration, we will consider you a self-pay patient. In this case a payment of $90 for a first visit and $70 for each follow-up visit is due at the time of service.

<u>Self-pay patients</u>
If you do not have insurance coverage, you will be considered a self-pay patient. The Clinic's rates for self-pay patients, due at the time of service, are $90 for a first visit and $70 for each follow-up visit.

<u>Miscellaneous fees</u>

a. The Clinic completes forms (i.e. disability) for a fee of $25 per form, paid in advance.
b. If you cannot keep your scheduled appointment, please give 48 hours notice. A missed appointment fee of $25 may be charged for failure to keep appointments without adequate notice of cancellation.
c. The Clinic charges a $25 fee for any returned check.

Individual billing

All family members receiving services at the Clinic will be billed under their own account. Monthly statements on accounts with a patient due balance will be mailed to the responsible party listed on the account. Accounts with unpaid balances will ultimately placed with an outside collection agency.

Treatment of a child whose parents are divorced

The responsibility for payment for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the parents/guardians involved, exclusive of the Clinic.

III. ACKNOWLEDGEMENT

I have read the above and agree to comply with the same.

____________________	____
Date	Signature of patient or person authorized to consent