Dermatology of the Berkshires pc

VICTORIA R. CAVALLI, M.D. BOARD CERTIFIED DERMATOLOGIST

INSURANCE/PAYMENT INFORMATION

Name: _____ DOB: _____

Thank you for choosing Dermatology of the Berkshires, P.C. for your health care needs. Along with providing you with quality service, Dermatology of the Berkshires, P.C. would also like to assist you with your billing needs. Please read the provisions below and mark the billing class that represents you:

_____ 1. Medicare only. Dermatology of the Berkshires, P.C. will file Medicare for you. Dermatology of the Berkshires, P.C. accepts assignment; however, you will still be responsible for the 20% that Medicare does not cover.

_____ 2. Medicare/Supplement. Dermatology of the Berkshires, P.C. will file both insurances. However, claims denied, rejected or partially paid by your supplemental carrier will be your responsibility in 30 days.

_____ 3. HMO. Dermatology of the Berkshires, P.C. will file to your insurance carrier. It will be your responsibility to obtain necessary authorization by your primary care physician. Visits not authorized will be your responsibility. You will be responsible for your copayment.

_____ 4. PPO. Dermatology of the Berkshires, P.C. will file to your insurance carrier. You will be responsible for any coinsurance, copayments and deductibles. Patients going out of their network will be responsible for payment at a higher rate.

__**X**__ 5. Self-Pay. Payment is due at the time services are rendered unless prior arrangements have been made. Dermatology of the Berkshires, P.C. will accept cash, checks, Visa and MasterCard.

Monthly statements will be sent to advise patients as to the status of their account.

I understand the billing procedures of Dermatology of the Berkshires, P.C. and agree to pay any balances that are my responsibility. Balances unpaid will result in collection actions.

Signature: _____ Date: _____

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 copayments 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 preverified and you will be asked to pay any unmet deductible, non-covered services and copayments. In the event that your account must be turned over to collections, a $20.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Signature: _____ Date: _____