**Klein Dermatology & Associates**

**5200 Meadows Road, Suite 250**

**Lake Oswego, OR 97035**

**Financial Policy**

PATIENTS: PLEASE READ CAREFULLY AND SIGN

1. It is the responsibility of the patient to provide KDA with current insurance information at the time of the visit. If you cannot provide your insurance card to be copied, you will be considered a self-pay patient until the information is received. Due to constantly changing insurance plans and identification numbers, you will be asked for your current insurance and personal information annually.
2. KDA will bill medical claims to insurance companies we are contracted with; however, we are not contracted with all insurance companies. It is the responsibility of the patient to verify whether or not Dr. Klein is a contracted provider. Some examples of non-contracted companies include: Health Net, Pacificare, Oregon Health Plan, and PHCS. All out-of-network deductibles and balances will be the liability of the patient and are due date of service.
3. KDA will assess a $35 returned check fee. The fee is in addition to the face value of the returned check.
4. KDA will bill up to two insurance companies on your behalf. As a courtesy to our patients, statements are not sent to the patient until after we receive a response from the insurance company. If we receive no response from the insurance company after the 3rd statement billing cycle, the account balance is transferred to patient’s responsibility.
5. For patients with HMO/managed care insurance plans: Receiving a referral from your primary care physician, prior to your visit, is the responsibility of the patient. If you choose to be seen without a referral at the time of service, you will be asked to sign a financial disclaimer form.
6. Copays are part of our contractual agreement with insurance companies and are due at the time of service.
7. Self-pay visits (visits not billed to insurance) are due in full on the date of service.
8. Payments for cosmetic and non-covered services are due in full the day the service is performed. If you choose to have a non-covered service performed and wish to have your insurance billed, you will be asked to sign a financial disclaimer form. It is up to the discretion of the provider whether or not your insurance can be billed.
9. Delinquent accounts more than 90 days past due are subject to collection activity including a collection service and dismissal from the practice. Patients are always notified in writing several times prior to any action.
10. KDA recognizes that there are times when full payment on a patient’s account is not feasible. We try our best to work with our patients. We accept cash and all major credit cards as payment. Our bookkeeper is trained to work with patients in setting up customized payment plans.
11. Guarantors bringing in a minor for medical care are responsible for signing the financial waiver assigning responsibility for the payment of that day’s service. All balances not covered by the insurance company are the full responsibility of the guarantor.
12. Divorced Parents: KDA will not be responsible for disputes between parents due to divorce. The parent who brings the child(ren) to our office will be responsible for the account of the child(ren). If the courts hold a specific parent responsible for providing healthcare coverage, the dispute is between the parents and will not be arbitrated by our office.

**I agree to all policies listed in this billing protocol and accept financial responsibility for treatment received at**

**Klein Dermatology & Associates.**

**PATIENT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**\*SIGNATURE** *(patient or responsible party)* **DATE**

\**By typing your name above you agree it will qualify as your electronic signature*

**Klein Dermatology & Associates**

Acknowledgement of Privacy Notice and Patient Rights

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive our Notice before signing this acknowledgement. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy upon request.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been offered to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

\*Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Individual or Personal Representative)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Authorization to Discuss Patient Medical Care

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_, give permission for the following person/people to obtain medical information on my behalf and speak with the medical staff of Klein Dermatology & Associates regarding any of my medical needs and/or billing information.

***Exclusions:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent □ Guardian □ Other □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent □ Guardian □ Other □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent □ Guardian □ Other □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\**By typing your name above you agree it will qualify as your electronic signature*