SNAKE RIVER
dermatology

Financial Responsibility

In order to establish optimal relations with our patients and avoid misunderstandings we are to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA & MASTERCARD FOR YOUR CONVENIENCE. Further, your signature authorizes the release of medical information to your primary care or referring physician, to consultations and to process insurance claims/applications and prescriptions. I authorize payment of medical benefits to the physician.

I understand I am financially responsible for all charges regardless of third party involvement. I agree to pay any deductible, co-insurance, co-pay, or any services deemed as "non-covered benefit" by my insurance at the time services are rendered. I understand that failure to pay outstanding balances within 90 days of notification will be sent to an outside billing service. Payment arrangements may be set up with the billing service. If payment arrangement cannot be agreed upon, the amount due will be considered delinquent and may be subject to the legal action/assignment of a collection agency. If legal action ensues between parties to this agreement, the prevailing party shall be entitled to recover reasonable attorney's fee and costs.
HIPAA compliant: I acknowledge I have had the opportunity to read Brock A. Andersen, MD Notice of Privacy Practices and a copy was made available.

_____ _____

Witness Signature Date Patient/Agent/Guardian Signature Date

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