TRI-CITY DERMATOLOGY

112 Columbia Point Drive, Suite 105
Richland, WA 99352
Tel: (509) 873-7140
Fax: (509) 818-1303

OFFICE AND FINANCIAL POLICIES

OFFICE POLICIES

APPOINTMENT POLICY

Tri-City Dermatology understands that circumstances change. Please be respectful of our other patients and staff by adhering to your scheduled appointment. Appointments for patients arriving more than 15 minutes late are subject to cancellation. Please call if you will be late so we can try to accommodate you and our other patients. We request a minimum of 24-hour notice for cancelation of an appointment. In the event this is not possible, please call our office, as soon as possible, so your scheduled time may be offered to another patient. Patients who repeatedly disregard these requests are subject to termination with the practice at the discretion of the provider.

MINOR PATIENT POLICY

Any patient under 18 years of age are required to have a legal guardian accompany them to all appointments.

FINANCIAL POLICY

The Practice requires payment of co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service. Balances from previous services must be paid before additional services will be rendered. Please contact us if you are unable to pay your balance to discuss payment plans.
I understand that I am financially responsible for, and hereby agree to pay, all deductibles, co-pays, and co-insurance that are not covered by my insurance policy(s).

INSURANCE POLICIES

I hereby direct and consent to Tri-City Dermatology (the "Practice") and/or my physician(s) submitting claim(s) for payment to my insurance carrier for services rendered to me. I understand that the Practice and/or my physician(s) is not obligated to do so unless under contract with the insurer or bound by State or Federal regulations to process such claim.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to the Practice and/or the physician(s) who renders services to me. I guarantee prompt payment of all allowable charges (as determined by the Practice's and physician(s)'s contract with my insurance carrier) incurred by the Practice for services rendered after insurance payments are applied or such charges are not paid within a reasonable period of time by my insurance carrier or other third party payor. I agree to make payments on any remaining balance due in accordance with the Practice's policy for payment of such outstanding balance(s).

RELEASE OF RECORDS

I authorize the Practice and/or my physician(s) to release all or part of my medical record where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Practice is correct and complete for purposes of permitting the Practice and/or my physician(s) to submit claims for reimbursement. I accept full financial responsibility for non-disclosure of any and all insurance information.

BILLING COMMUNICATION AUTHORIZATION

I authorize the Practice and/or my physician(s) to communicate information regarding my billing account and the payment for services rendered to me to the individuals as stated on my Patient Registration.

The above stated policies are available for review at any time on our website or upon request from the front desk.
I have read and agree to all terms specified in the above Office and Financial Policies.

_____	_____
Patient Name	Parent/Guardian Name & Relationship (if other than patient)
_____	_____
Signature of Patient or Parent/Guardian	Date