Yamhill Valley Dermatology and Laser Center

706 NE EVANS STREET ■ McMINNVILLE, OR 97128 ■ WWW.YAMHILLDERM.COM

PAYMENT IS EXPECTED AT THE TIME OF VISIT FOR YOUR PART OF THE CHARGES

In consideration for services rendered to me by Richard I. Ecker, M.D., I hereby authorize payment of medical services to said physician. In addition, I authorize the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing. However, I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay all costs and expenses.

WE ACCEPT VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, CARE CREDIT AND LOCAL CHECKS FOR YOUR CONVENIENCE.

Medicare

You are financially responsible for any non-covered services under Medicare guidelines, as well as your 20% co-pay and any amounts applied to your yearly Medicare deductible.

Health Insurance: Co-pay, Deductible and co-insurance

If you have a co-pay, deductible and/or co-insurance that have not been met, you are required to pay on the day of service. We will submit the claim to your insurance company. **If payment is not received from your insurance company within 60 days, we will then look to you for payment of the entire balance (regardless of insurance status).** If payment is then received from your insurance company, a refund will be issued to you.

Laboratory Charges

If lab tests and/or pathology specimens are sent to outside laboratories, this will be billed separately from your **Yamhill Valley Dermatology** charges. The laboratory service will bill your insurance company for their charges.

No Health Insurance

If you are an uninsured patient to the office you will be required to **pay in full at the time of service.** We gladly give **estimates upon request**. Our office offers Care Credit (a financing plan for patients) Care Credit is available at **www.carecredit.com**. For more information ask the office or accounts manager.

Cosmetic Procedures

Cosmetics procedures, including laser treatments, are required to be paid in full at the time of service. Yamhill Valley Dermatology requires $100.00 deposit that will be forfeited if appointment is not cancelled with 24 hours notification. Yamhill Valley Dermatology **will not** bill any insurance for cosmetic services as these are elective and not covered by insurance carriers.

Collections

Account balances past 60 days due may be subject to collection procedures. A service charge of $10.00 per month will be applied to balances over 60 days past due. If your account becomes delinquent and is assigned to a collection agency, **you will be charged a $50.00 fee. You are also responsible for any collections fees including any reasonable attorney fees**. **All NSF checks will be charged a $35.00 overdraft fee.**

Refunds

If proceeds are received from your insurance company that leaves a credit balance on your account and you have a scheduled appointment to return to our office within 30 days, the credit will be applied directly to your total amount due. If you do not have an appointment scheduled within the next 30 days, a refund check will be issued to you.

Cancellation & No Show Policy

Your appointment time is reserved for you. If you cannot keep your appointment, please contact our office at least 24 hours prior to your appointment so another patient may use it. We appreciate your consideration to other patients who are waiting to get in. If you **no show** for an appointment or fail to provide 24 hours notices of cancellation, your account may be charged $50.00. By signing this form you acknowledge that you have read and understand our **"No show Policy."**

Medical Records/ Cancer Forms

There will be a charge of at least **$25.00** in advance for special services requested such as attorney request, Aflac, life or disability Insurance policies.

I understand the financial policy of this office and that regardless of insurance; I am ultimately responsible for payment of my account. I will observe the policies as outlined above.

Signed:____ **Date:**_______________________________________

Print Name:____ **Account Number:** _______________________________