

To better serve our patients at Hill Center for Dermatology, PC we have summarized important information regarding your visit.

REFERRALS: *Some* insurance companies require a referral from your primary care physician. This authorization indicates that the medical necessity of your visit has been verified. These must originate from your primary care physician and be approved prior to your appointment. Please do not schedule an appointment before receiving your authorization. Doing so could result in a denial from your insurance company and/or primary care physician and your visit may become your financial responsibility. If you are unsure if a referral is required, please call the member services phone number on your insurance card or contact your primary care physician.

APPOINTMENTS: Although it is not always attainable, we pride ourselves in staying on schedule. If you arrive late for your appointment, you may be asked to reschedule. We value your time and try very hard to make your experience with us a positive one. Please do not be discouraged if a treatment cannot be done at your first visit. Your initial appointment is to evaluate the problem. If time and insurance allows we will do our best to proceed with treatment to avoid additional visits to the office.

We are committed to meeting our patient's healthcare needs. No show and late cancellations waste time that other patients could use. 48 hour notice is requested.

INSURANCE: Please promptly notify us of any changes to your insurance. Co-payments and deductibles are requested at the time of service. Given correct information, we will submit the charges to your primary insurance company. ***Please be aware that some diagnosis and procedures are considered cosmetic, a non-covered benefit or surgical. Cryotherapy (liquid nitrogen), biopsies and excisions are considered "surgery" by most insurance companies and deductibles frequently apply. We recommend that you review your plan benefits prior to any procedure.***

In the event of no insurance coverage, full payment is required at the time of service. We accept cash, debit cards, Visa and MasterCard.

FINANCIAL POLICY: Co-payments and deductibles are due at the time of service. You will receive a statement for any remaining balance once insurance has paid their portion. Balances without payment after 60 days will result in the account being turned over to a collection agency and discharge from the practice. Returned checks are subject to a \$20 fee.

LAB FEES: When a biopsy is performed, the specimen is sent to an outside laboratory for interpretation by a pathologist specializing in dermatology. Often times your insurance company will dictate which laboratory is to be used. Depending on your coverage, you may receive a separate bill for these services.

Please let us know if you have any questions or if we may be of further assistance. Our goal is to provide professional, courteous care and we look forward to serving your dermatology needs.

Sincerely, Hill Center for Dermatology, PC

I have read and understand the above information. _____
Patient/Parent signature and date

_____ Print Patient Name

WELCOME TO THE HILL CENTER FOR DERMATOLOGY, P.C.

Please complete the information below and present your insurance card and picture ID to the receptionist for a photo copy. We are happy to assist you if needed.

PATIENT INFORMATION

LAST _____ **Middle Initial** _____ **FIRST** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone: Home (____) _____ **Work** (____) _____ **Date of Birth** _____

Gender M/F _____ **Primary Care/Referring Physician** _____

If Not Referred by Physician, How Did You Hear About Us? _____

Employer _____ **Student: Full-time / Part-Time**

Alternate Contact _____ **Relationship:** _____ **Phone(____)** _____

INSURANCE INFORMATION

Do you have insurance? Yes _____ **No** _____

Primary Insurance _____ **Relationship to Insured – Self/Spouse/Child**

Name of Insured (Guarantor) _____ **Date of Birth** _____

Address (if different than above) _____

Secondary Insurance _____ **Relationship to Insured – Self/Spouse/Child**

Name of Insured (Guarantor) _____ **Date of Birth** _____

CoPays and any charges not covered by insurance are required at the time of service.

AUTHORIZATION TO RELEASE INFORMATION & PAYMENT OF MEDICAL BENEFITS

I certify that I have read and understand the above information and the questions have been accurately answered. I hereby authorize the release of any medical information necessary to process insurance claims and authorize payment of benefits to the Hill Center for Dermatology, P.C. I agree to be responsible for payment of all services rendered on my behalf, or my dependants, in accordance with my plan benefits at the time of all service unless prior arrangements have been made.

By signing below I have accepted and consent to the treatment recommended and authorize this facility to contact myself with necessary medical information via telephone or other means of communication.

Patient/Responsible Person Signature _____ **Date** _____

Please read and sign back page

*Hill Center for Dermatology, PC
17560 S. Golden Road, Suite 100
Golden, CO 80401
303-526-1117*

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH
INFORMATION FOR TREATMENT, PAYMENT OR
HEALTHCARE OPERATIONS**

NAME: _____

DATE OF BIRTH: _____

I understand that Hill Center for Dermatology, PC originates and maintains health records describing my personal and family health history, symptoms, examinations, test results, diagnosis, treatment and plans for future care.

I UNDERSTAND THIS INFORMATION SERVES AS:

- A basis for planning my care and treatment.
- A means of communication with healthcare professionals who contribute to or participate with my care.
- A source to provide diagnosis and treatment to my insurance company and/or third party payor for billing purposes.
- A means by which my insurance company and/or third party payor can verify services.
- A tool for ensuring quality of care and competency of healthcare professionals.

I UNDERSTAND I HAVE THE RIGHT:

- To restrict how my healthcare information is used or disclosed.

All requests for restrictions must be in writing and given to your provider.

Signature of patient or guardian

Date