MDC Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

New Patients with medical insurance must present their insurance card(s) and a photo I.D. at their first visit. Uninsured patients must present a photo I.D. The patient will not be seen without these. Uninsured patients will be given an estimate during the visit for recommended procedures. Payment in full for services rendered to uninsured patients are due at the time of service.

Please be aware that it is your responsibility to know your insurance policy, benefits and coverage in relation to Dermatology. We do not acknowledge responsibility for each individual plan. Laboratory charges are not included in the cost of procedures performed and all billing for laboratory services will be billed by the laboratory.

Name of Insurance Company:_____
Policy Holder Name:_____**Relationship to you**_____
(First) (MI) (Last)
Name of Secondary and Tertiary Insurance Company(s)_____
Policy Holder Name_____**Relationship to you**_____
(First) (M) (Last)
Address:_____**Date of Birth**____/_____/_____
(Street) (City) (State) (Zip code)

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following.

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries to release any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and requested payment of medical insurance benefits either to myself or the party who accepts assignment. Regulation pertaining to Medicare assignment of benefits applies.

I hereby authorize direct payment of surgical/medical benefits to Melbourne Dermatology Center for services rendered by Dr. Wiener. I understand that I am financially responsible for all balances not covered including cosmetic services, Co-payments and deductibles.

I have read the Financial Policy of Melbourne Dermatology center and I agree to comply with its terms.

_____ _____
Signature Date

_____
Print Name

_____ _____
MDC Witness Date

PLEASE COMPLETE BOTH SIDES

Primary Care Physician_____

Pharmacy Information:
Preferred pharmacy_____
Pharmacy location: _____
Pharmacy telephone number: _____

Emergency Contact Information
Name:_____
Relationship: _____
Address: _____
Phone: _____

Protected Health Information Release :
In compliance with **HIPAA** regulations, and in order to facilitate requests for your protected health information, please complete the following.

I authorize the person(s) listed below to have access to any of my protected health information, including HIV, drug and alcohol abuse and psychiatric records. **Melbourne Dermatology Center** is permitted to share with them test results and information disclosed during my office visits. For copies of medical records, I understand that I will need to sign a separate authorization. Please list below, those individuals that you wish to receive your protected health information.

_____ _____
Full name Relationship

_____ _____
Full name Relationship

In addition to those individuals listed above, I request that you may also notify me of test results, appointment confirmations, and other information related to my health in the following manner:

___Leaving a message on my home phone at _____
___Leaving a message on my work phone at _____
___Leaving a message on my cell phone at _____
___EMAIL Address: _____

I understand that I will update **Melbourne Dermatology Center** with any changes in the above listed contact information. I understand and direct that this authorization will remain in effect until is revoked by me in writing.

_____ _____
Patient Name Date

_____
Patient Signature

_____ _____
Witness Name Date