DERMATOLOGY CLINIC OF IDAHO

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DIPLOMATE AMERICAN BOARD OF DERMATOLOGY
FELLOW AMERICAN ACADEMY OF DERMATOLOGY
FELLOW AMERICAN SOCIETY FOR MOHS SURGERY

# Receipt of Notice of Privacy Practices/Credit and Cancellation Policy

In order to establish optimal relations with our patients and avoid misunderstandings, we want to inform you of our privacy and credit policies. If you would like to see the complete HIPAA policy, pamphlets are available at the front desk.
PAYMENT IS EXPECTED AT THE TIME OF SERVICE. WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER, FOR YOUR CONVENIENCE.
We charge a $20 fee on all returned checks.
**A $50 fee may be charged for "No Shows" and cancellations less than 24 hours before scheduled visit. This fee can be paid at the time of the cancellation or will be assessed before scheduling your next appointment.**

**It is important that you keep in contact with our billing department if you cannot pay your balance in full.** You will receive 2 statements after we have heard from your insurance. Then we will take further action to collect. Your signature authorizes the release of medical information to you, your primary care or referring physicians, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.
Your signature also authorizes payment of medical benefits to the physician.

Since our providers are specialists, your co pay may be different than indicated on your card.
If you have a procedure, your insurance may apply those charges to your deductible, if it has not been met.
Our office can never guarantee your coverage or benefits. Only your insurance customer service department can guarantee that our providers are in network.

**We will contact you for appointments, test results, billing problems, etc., in any of the following manner: postcard, letter, telephone and email.**

Do we have your permission to discuss your medical condition with any member of your household? Yes ☐ No ☐

If yes, whom: _____ Relationship_____

I acknowledge I have had the opportunity to read the Dermatology Clinic of Idaho Notice of Privacy Practices/Credit Policy and copies were made available to me.

_____ _____ ___ _____
Signature- Patient or Personal Representative Relationship Date

_____ _____ _____
Print Patient Name Patient date of birth