Mountain West Dermatology, PC
2655 Little Bookcliff Drive
Grand Junction, CO. 81501 Tel: (970) 242-7273
Patient Release Form and Disclosure of Charges

Today's Date:___/___/___
Patient's Name:_____DOB:___/___/___

FEES AND OTHER CHARGES: Our fees are based on the time and skill required to handle your particular problem and are reasonable and customary for this area. All fees due from patients, including uninsured fees, deductibles, and co-pays, are due and payable at the time of your visit. Additional charges may be necessary after your visit. Charges for these procedures will be billed later.

MISSED APPOINTMENTS: If you do not show for any appointment without calling to cancel at least 24 hours prior, you will be charged a $20.00 no show fee. If you do not show for a scheduled surgical procedure without calling to cancel 24 hours prior, you will be charged a $75.00 no show fee.CO-PAYMENTS:

Co-payments are due at the time of service. There will be a $10.00 processing fee if co-payments are not received at the time of service.

I understand, and by initialing and signing below, I acknowledge and agree that I am financially responsible for and must pay the fees for services provided to me by Mountain West Dermatology, P.C., and the charges described above. I agree to pay interest at the rate of 12% per annum for balances not paid within 30 calendar days after the services are provided or first invoiced. I also agree to pay or reimburse (a) court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance; (b) a collection fee of _% if my account is assigned to a collection agency; and (c) a billing fee of $_____and a certified letter fee of $8.10 for each certified letter mailed to me. Initials:_____

BIOPSY OR RELATED PROCEDURE POLICY: Patients who have a biopsy or related procedure that requires tissue examination will be billed separately by the pathology provider. Standard Dermatology care requires that tissue removed be submitted for pathology examination. Initials:____

RELEASE OF INFORMATION: I authorize the release of my medical information to my PCP or referring physician, to consultants, and as needed to process insurance claims and prescriptions. I also authorize payment of medical benefits to the physician. I understand that I am financially responsible for and must pay any balance not covered by my insurance. Initials:____

I have read the above fee and procedure policies and understand these policies. I agree to pay the fees for services received and other charges described here.

_____Date:___/___/___

Patient or Responsible Party Signature

MEDICARE PATIENTS ONLY: I authorize Mountain West Dermatology, PC to release to the Health Care Financing Administration, Medigap insurers, or my private insurance carrier any information needed to determine these benefits or the benefits of related services. **Patients without supplemental insurance must pay 20% co-insurance for first layer of Mohs surgery and for any surgical procedure ½ hour or greater.** I understand that I am financially responsible for any balance not covered by my insurance. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ Date:___/___/___

Signature as it appears on Medicare Card