Mountain West Dermatology, P.C.
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: _____ Birth date: _____

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 no show for any appointment other than cosmetic without calling to cancel at least 24 hours prior, you will be charged a $20.00 no show fee. If you no 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.

All fees and other charges not paid at the time of the visit shall accrue interest at the rate of 1% per month (12% per annum) beginning 30 calendar days from the date services were provided or charges first assessed. Additionally, you are responsible to reimburse Mountain West Dermatology, P.C. for any costs and reasonable attorney fees it incurred in order to collect an overdue account.

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 primary care 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 any balance not covered by my insurance.

I have read the above fee and procedure policies and understand these policies.

_____ Date_____/_____/_____

Patient or Responsible Party Signature

MEDICARE PATIENTS ONLY: I authorize Mountain West Dermatology, P.C. 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 1/2 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.

Signature as it appears on Medicare Card

_____Date_____/_____/_____