SENTER MD
DERMATOLOGY

636 Barrow Street • Anchorage, Alaska • 99501 • phone (907) 276-1315 • fax (907) 278-7129

I, _____, understand that all services rendered to me by the providers at Senter Dermatology are my financial responsibility, and that the provider will bill my insurance company as a courtesy. SENTER DERMATOLOGY IS NOT CONTRACTED WITH MEDICAID, MEDICARE, TRICARE, VA, CHAMPUS OR HUMANA.

I agree to pay my office co-pay amount (if applicable) and 20% of any remaining amount owed at the time of my visit. I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I authorize my insurance company to pay my benefits directly to Senter Dermatology and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional charges over and above the insurance payment.

I am aware that I am responsible for any balance from any procedures/treatments that have been denied (especially that involve Botox® or lasers), REGARDLESS if my insurance company has stated that they approve said procedures/treatments.

If I cannot provide my insurance card at the time of visit, I will pay IN FULL and will be given the proper paperwork to submit to insurance myself.

I have chosen to assign benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by your insurance company.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me directly, I will forward the payment to Senter Dermatology within 72 hours. I agree that if I fail to send the payment to Senter Dermatology and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. Any violations of this agreement will, at the provider's election, terminate patient charge privileges with Senter Dermatology and bring any balance owed by me, the patient, to Senter Dermatology to be due and payable immediately.

I authorize Senter Dermatology to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf, and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ _____

Signature of Patient/Policy Holder **Date**

INSURANCE INFORMATION

If you do not have the following information readily available at the time of your visit you will be asked to pay your visit in full. Please present card to front desk. We only submit to a maximum of two insurances. Proper paperwork can be given to you to submit to any remaining insurances yourself.

PRIMARY INSURANCE

Insurance Company Name: _____ Insurance Phone: _____

Insurance Company Address: _____

Insurance Identification Number: _____ Insurance Group Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____/_____/_____

Subscriber Address: _____

Subscriber Social Security Number: _____ Subscriber Contact Number: _____

Subscriber's Relationship to the Patient: ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT/GUARDIAN** ☐ **OTHER**_____

SECONDARY INSURANCE

Insurance Company Name: _____ Insurance Phone: _____

Insurance Company Address: _____

Insurance Identification Number: _____ Insurance Group Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____/_____/_____

Subscriber Address: _____

Subscriber Social Security Number: _____ Subscriber Contact Number: _____

Subscriber's Relationship to the Patient: ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT/GUARDIAN** ☐ **OTHER**_____

I attest that the above information is accurate and I understand Senter Dermatology's office policies.

X: _____ _____ _____/_____/_____

Signature Printed Name Date