WEST HILLS DERMATOLOGY GROUP

7320 WOODLAKE AVE, SUITE 340 WEST HILLS, CA 91307
(818) 592-6005 p (818) 592-6088 f www.westhillsdermatology.com
□*Farnaz Gaminchi, M.D.* □*Tasneem Poonawalla, M.D.* □*Kerry Schlosser, PA-C*

Conditions of Registration and Financial Policy

Name of Patient: _____
Date of Birth: _____

The following are our conditions of registration as well as our policies with respect to the billing and collections of your account. By signing below, you are agreeing to be bound by these terms.

- **BASIC POLICY** Copays & any outstanding balance are due at the time service is rendered unless prior arrangements have been made by our office. We charge a $5.00 processing fee for billing the office copay. We allow up to three (3) per calendar year.
- **FINANCE CHARGE** balances owed by the patient or responsible party that are over 30 days will accrue a finance charge of 1.5% that will be added to the account for each additional month that the account is past due. This represents an annual percentage rate of eighteen (18%) percent. Accounts over 90 days will be referred to a collection company.
- **FOR PATIENTS WITH MEDICARE** We will bill Medicare on your behalf. As a courtesy, we will also bill secondary insurance carriers on your behalf. You are responsible for all co-insurance payments & annual deductible if not covered.
- **FOR PATIENTS WITH INSURANCE** All co-payments and deductibles are due at the time of service. We will bill insurance carriers on your behalf if we have a current contract with the carrier. We will submit a courtesy claim on your behalf to insurance carriers with which we do not participate. Please be advised that your agreement with your insurance carrier is a private one and that ultimately, you are responsible for payment. If an insurance carrier has not paid a claim within 60 days of billing, our fees are due and payable from you.
- **NONCOVERED SERVICES** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial.
- **MISSED APPOINTMENTS** In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel an appointment. You may be charged $25.00 for each appointment that was missed or not canceled with 24 hour notice. **SATURDAY missed appointments or same day cancellation fee is $100 if 48 hour notice is NOT given.** Missing more than two appointments without providing 24 hours' notice is grounds for discharge from the practice. **MOHS cancellation fee is $300** & requires two (2) week prior notice.
- **COSMETIC APPOINTMENTS** requires at least a min of five (5) working days' notice to cancel an appointment. A deposit of 50% of procedure is required upon scheduling, reimbursed with policy compliance.
- **RETURNED CHECKS** There will be a fee of$25.00 charged by this office for each check returned to us by your bank.
- **LATE ARRIVAL TIME** we understand emergencies occur we ask that you please inform us if you will be **more than ten (10) min late**. Depending on the procedure(s) in some cases we may need to reschedule due to the time allotted per patient and avoiding potential delays with the schedule. A missed appt fee of $25 may be assessed to your account if prior notification **was not** given.
- **COLLECTION AGENCY COSTS** In the event that your account is forwarded to a collection agency; you agree to pay finance charges assessed to your account for past due balances, additional fees may be assessed if your balance is forwarded to the collection agency along with attorney fees or court costs. Please speak to our billing department for further information.

EMERGENCY CONTACT INFORMATION:

In case of Emergency, who should be notified? _____

Phone ( ) _____

Relationship to patient: _____

Do you give our office permission to discuss your medical information with family members?

❑ YES ❑ NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): (_____)_____ Phone # (evening): (_____)_____

May we leave personal medical information on your answering machine or cell phone?
❑ YES ❑ NO

May we e-mail personal medical information to you? ❑YES ❑ NO

E-mail address: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:
My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _____Date _____

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ASSIGNMENT OF INSURANCE BENEFITS. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to **West Hills Dermatology Group & Affiliates**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not the charges are paid by said insurance. I hereby authorized said assignee to release all information necessary to adjudicate all claims and secure payment for services rendered.

_____ _____ ___/___/___
Patient Signature (or Legal Guardian) Printed Name Date

_____ _____ ___/___/___
Witness Signature Printed Name Date