

# **Aloha Dermatology, LLC**

## **Financial Policy**

### **Patients with Non-Contracted Insurance Carriers**

- Patients with non-contracted insurance carriers will pay in full at the time of service.
- A driver's license or government-issued ID card is required to verify that we are providing services to the appropriate person and to protect our patients from identity theft.
- For patients with non-contracted carriers that allow "out-of-network" provider care, we can submit a claim for you on an unassigned basis. Your insurer may then directly reimburse you for a portion of allowable charges, as specified in your policy. **We can give no promises, written or implied, regarding the amount of reimbursement you may receive from your insurance carrier.** Procedures that are not medically necessary are considered cosmetic and will **not** be submitted for insurance reimbursement.
- Your insurance policy is a contract between you and your insurance company. It is your responsibility to know what services your health insurance covers, and to contact your insurance company with any coverage issues.
- We accept cash, check, or credit cards. There will be a \$25.00 fee for any checks returned due to insufficient funds.

<b>Primary Insurance:</b> _____	Policy or ID Number: _____
Policy holder: _____	Policy holder's date of birth : ___/___/___
Address (if different than patient): _____	
Relation to patient: <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse	
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<b>Secondary Insurance:</b> _____	Policy or ID Number: _____
Policy holder: _____	Policy holder's date of birth : ___/___/___
Address (if different than patient): _____	
Relation to patient: <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse	

I authorize Aloha Dermatology LLC to release to the above insurance company(s) any information needed for this or a related insurance claim(s). I permit a photocopy of this authorization to be used in place of the original document.

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Responsible Party