# *Aloha Dermatology, LLC*
# *Financial Policy and Insurance*

## ***Patients with Contracted Insurance Carriers***

- 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.

- As with hotels and rental car agencies, we now require that you leave credit card information and authorization for us to charge your "*Patient Responsibility*" portion of the bill (example: co-pays, tax, deductibles). If you prefer, you may leave a deposit with us at the time of visit.

- Procedures that are considered cosmetic, or that are known not to be covered by your insurance policy, **will not** be submitted to your insurance company. Payment for these procedures is due at the time of service.

- For questions concerning the details of your insurance coverage please contact your insurance provider prior to your appointment.

- We accept cash, check, or credit cards. There will be a $25.00 fee for any checks returned due to insufficient funds.

**Primary Insurance**: _____ Policy or ID Number: _____

Policy holder: _____ Policy holder's date of birth : ___/____/___

Address (if different than patient): _____

Relation to patient: __self __ parent __ spouse

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**Secondary Insurance**: _____ Policy or ID Number: _____

Policy holder: _____ Policy holder's date of birth : ___/____/___

Address (if different than patient): _____

Relation to patient: __self __ parent __ spouse

I have read and understand the financial policies of Aloha Dermatology LLC and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

I authorize payment of medical benefits to Aloha Dermatology LLC, from my insurance company(s) listed above, for services rendered by Dr. Winona Wong. I also authorize Aloha Dermatology LLC to release to my insurance company(s) any information needed for this or any related insurance claim(s). I agree that a photocopy of this agreement shall be as valid as the original.

_____ _____

Signature of Patient or Responsible Party: Date

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Print Name of Patient