Patient Financial Policy

Robert Bentley MD / Robert J. Bentley, LLC, believes that part of good health care practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

PAYMENT is expected at the time of your visit, at Check In, prior to seeing the Doctor. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre- existing condition clause, payment in full is expected at the time of your visit. A copy of your Insurance Card and a copy of your Driver's License (to prevent identity Theft) must be presented at the time of your appointment.

We have a contractual agreement with your Insurance Provider to collect Co-pays at the time of your visit. Your Insurance Provider determines the amount of your Co-Pay.

INSURANCE We are a participating Provider with several insurance plans. We will file all these insurance claims. **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.** If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will promptly refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim is rejected for the lack of one. This includes but is not limited to VA Patients and Medicaid Patients.

We highly recommend you also contact your insurance carrier and check into your coverage for Dermatology. Do not assume that you will not owe anything if you have more than one insurance policy.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge.

RETURNED CHECKS will incur a $30.00 service charge. You will be asked to bring cash, certified funds, or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collection.

RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Dermatology Care of Alabama/ Robert J. Bentley LLC, for charges not covered by the assignment of insurance benefits.

SELF PAY PATIENTS / PATIENTS WHO ARE UNINSURED: All Payment is expected at time of service. Effective 2022, Dermatology Care of Alabama/Robert J. Bentley LLC Self Pay Policy is as follows:

New Patients - $200.00 Co-Pay Due at Check-In– This amount applies to the cost and coverage of the Office Visit ONLY. This does not include the cost of any procedure the Doctor deems necessary during the clinical exam. The remaining cost of any additional procedure beyond the initial Office visit will be totaled before you leave.

Unless a prior arrangement has been made, you are responsible for the entire cost of any clinical procedure performed by the Doctor at Check Out.

Returning Patients Follow-Up Patients - $150.00 Co-pay Due at Check-In - This amount is applied to the cost and coverage of the Office Visit ONLY. This does not include the cost of any procedure the Doctor deems necessary during the clinical exam. The remaining cost of any additional procedure beyond the initial Office visit will be totaled before you leave.

Unless a prior arrangement has been made, you are responsible for the entire cost of any clinical procedure performed by the Doctor at Check Out.

Dermatology Care of Alabama/ Robert J Bentley LLC does not extend credit. All services are expected to be paid in full at the time of service.

COLLECTION FEES: I understand that if my account is placed in collection status, any additional fees incurred will be added to my outstanding balance. This includes late fees, collections agency fees, court costs, interest, and fines. I understand that these additional fees will be my personal responsibility to pay in full.

I have read and understand the practice's financial policy and I agree to be bound by its terms.

I also understand and agree that such terms may be amended by the practice.

_____

(Signature of Patient or Legal Guardian)

_____

(Printed Name of Patient)

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Dermatology Care of Alabama/Robert J Bentley LLC, to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Robert J. Bentley, LLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices before signing this consent.
Robert J Bentley, LLC reserves the right to revise its Notice of Privacy Practices at any time. I have the right to request that Robert J. Bentley, LLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. With this consent, Dermatology Care of Alabama/ Robert J Bentley, LLC may call my home/mobile phone and leave a message on voice mail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.
□ yes □ no

With this consent, Dermatology Care of Alabama/Robert J. Bentley, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as patient statements.
□ yes □ no

With this consent, Dermatology Care of Alabama/Robert J. Bentley, LLC may e-mail any items that assist the practice in carrying out TPO, such as appointment reminders or patient statements.
□ yes □ no

The following person(s) may contact Dermatology Care of Alabama/Robert J. Bentley, LLC inquiring about my health information. You have my permission to release information to them.

Name_____ Relationship_____ Phone _____

Name_____ Relationship_____ Phone _____

I may revoke my consent in writing except if the practice has already made disclosures in reliance on my prior consent.

If I do not sign this consent, or later revoke it, Dermatology Care of Alabama/Robert J. Bentley, LLC may decline to provide treatment to me.

Signature of Patient or Legal Guardian_____

Print Patient's Name _____Date_____

Print Name of Patient or Legal Guardian, if applicable_____

Dermatology Care of Alabama

MEDICAL HISTORY FORM: PLEASE GIVE THIS SHEET TO YOUR PROVIDER

Patient Name: _____

Reason for Visit: _____

Pharmacy: _____ Height: _____ Weight: _____

PAST MEDICAL HISTORY: Please circle all that apply. NONE/OTHER are also options.

Anxiety	Colon Cancer	Heart condition	Hypothyroidism
Arthritis	Coronary Artery Disease	Hepatitis	Lung Cancer
Asthma	Depression	High Blood Pressure	Lymphoma
Atrial Fibrillation	Diabetes	High Cholesterol	Prostate Cancer
Bone Marrow Trans.	End Stage Renal Disease	HIV/AIDS	Radiation Treatment
BPH/Prostate Enlarged	GERD (reflux)	Thyroid Problems	Seizures
Breast Cancer	Hearing Loss	Hyperthyroidism	Stroke

NONE

Other: _____

Past Surgeries: _____

_____

SKIN DISEASE HISTORY: Have you ever been diagnosed with any of the following skin diseases by another Dermatologist? Please circle all that apply. (NONE/OTHER are also options.)

Acne	Hay Fever/Allergies	Basal Cell Carcinoma	Precancerous Moles
Actinic Keratosis	Melanoma	Eczema	NONE
Blistering Sunburns	Psoriasis	Flaking/Itchy Scalp	OTHER:
Dry Skin	Squamous Cell	Poison Ivy	

Medications:_____

_____

Allergies: _____