ROBERT B. STRIMLING, MD and Associates, LLC
Practice Limited to Dermatology, Dermatologic/MOHS Surgery,
& Cosmetic & Laser Surgery

Summerlin Hospital Complex, Medical Office Building III
10105 Banburry Cross Dr., Suite 350
Las Vegas, NV 89144 (702) 243-6400

Practice Policies, Disclosures & SIGNATURE ON FILE

I hereby give my consent to and authorize medical examination and all treatment that may be advisable or necessary, including routine dermatologic procedures, such as biopsy or removal of minor skin lesions or treatment with liquid nitrogen, which will be explained in detail before treatment; and the following:
(Our doctors usually perform pathologic interpretations for any skin lesions removed; typically 3-7 days after the office visit, which incurs a separate charge.
On occasion, the doctor at his discretion may feel that a second opinion is warranted and if so, another separate charge will be incurred from an outside lab.)
This above consent shall apply to all office visits, now and in the future, unless I revoke this authorization via written certified letter.
Furthermore, I will inform this office of any changes in my medical history, insurance coverage, telephone number and/or address as they occur;
and periodically, verify (with office staff) that my above information on record is accurate. I certify this information is true and correct to the best of my knowledge.

I UNDERSTAND AND ACCEPT THAT I AM ULTIMATELY FINANCIALLY RESPONSIBLE FOR ALL EXPENSES INCURRED FOR SERVICES PROVIDED REGARDLESS OF MY INSURANCE STATUS. AND I GIVE CONSENT TO BE CONTACTED VIA ANY OR ALL CONTACT INFO THAT I HAVE PROVIDED.

PLEASE NOTE - PAYMENT IS EXPECTED AND DUE AT THE TIME OF SERVICE FOR "YOUR PORTION" OF CHARGES;
that includes any co-pays, co-insurance, any remaining deductible and non-covered or cosmetic services, as we do not regularly bill patients for these charges.
Please note it is your responsibility to know your co-pay, co-insurance, deductible and other pertinent plan specifics and to update us with this information regularly.
If you (or we) do not know the amount of your co-pay, 20% of the total charges will be collected at the time of service.
For your convenience, we accept cash, personal check with valid identification (i.e. driver's license), and VISA / MASTER CARD / AMEX / DISCOVER.
There will be a charge of $25.00 for all returned checks.
If copies of records are requested, there is a $15.00 minimum handling fee plus $.60 per page or otherwise as determined by law.

Please note that we bill your insurance as a **courtesy**. In order to do so, we must have updated and accurate insurance information.
If a completed claim form is required to accompany our billing, we must have that completed form at the time of your office visit.
Please be aware that your insurance policy is a contract between you and your insurance company. We are not a party to that contract.
Your account with this office is your responsibility whether or not your insurance company pays.
We will bill your insurance at least one time. If you have not received notification from your insurance company that we have been paid within 45 days of your date of service, we ask that you please contact your insurance company to check the status of your claim!!!

Although we are preferred providers for most managed care organizations; and thus, have agreed to accept reduced payment for our professional services; some insurers may use a variety of tactics to avoid, delay or improperly pay for our services, in addition to our agreed upon reduced ("contracted") fee schedule.
As your advocate, we will make a reasonable effort to obtain appropriate payment from your insurance company. However, if your insurance company has not paid your bill properly, in full (per contracted fees) within 90 days from the date of service, any balance will be due and payable by you, regardless of whether or not your insurance company states otherwise. You will only be responsible for our determined contracted fee for each service provided.
Also, you acknowledge here that we will inform you and obtain your approval prior to providing any known non-covered services, e.g. cosmetic services.
Furthermore, we cannot anticipate if your insurer will deny a service as non-covered that is usually considered covered. (Although, some insurers may use this tactic to avoid payment; you also agree to be responsible for our charges related to such services, despite any contrary rhetoric your insurer may claim.)

In the event your account becomes past due, your balance will accrue interest at the rate of 1% per month, (12% per annum).
A past due account is an account not paid within 30 days from our 1st date of billing you.
In the event that you fail to pay in full or make any kind of satisfactory arrangement for payment or otherwise within 60 days of your first bill,
(or we are unable to locate/notify you of your account status despite reasonable effort) your balance will be turned over to our outside office Collection Agency.
A $25 charge will be assessed to all collections accounts, in addition to any accrued interest.
If your account is referred to our Collection Agency, interest will continue to accrue at the rate noted herein.
In addition, you will be responsible for all Collection costs, Attorney fees, Court Costs, Service Fees & associated Miscellaneous Fees and Costs.

An adult accompanying a minor patient (the "responsible party") is responsible for full payment of the minor patient's account.

Please help us serve you better by keeping all scheduled appointments. Otherwise notify us as soon as possible if you are unable to keep your appointment.
If you fail to show for your appointment or cancel less than 24 hours prior your appointment, our policy is to charge you $25 for such missed appointments.
Also, we charge $25 per form to complete FMLA, disability, "Cancer Insurance Policy" forms or other similar forms, payable prior to completing such form(s).
We will retain your medical records for 5 years per NRS (Nevada Law), after which they will be destroyed unless legally required otherwise.

I herein authorize payment of medical benefits to Robert B. Strimling, MD & Associates, LLC, when an assigned claim is filed.
Also, my signature authorizes Robert B. Strimling, MD & Associates, LLC to release any medical information necessary to process my insurance claims.
Furthermore, my signature here acknowledges that Robert B. Strimling, MD and Associates, LLC has informed me that they have a Notice of Privacy Practices (which describes how medical information about me may be used and disclosed and how I can get access to this information) as in compliance with HIPAA.

I will not post on a Web site about Robert B. Strimling, MD or his associates / staff without his approval. Please let us know if you have any questions or concerns.
Our strict adherence to these policies serves to enhance our physician/patient relationship. My signature below indicates that I understand and accept these policies.

PRINT NAME_____ SS #_____

_____ DATE_____

Signature of Patient or Legal Guardian