SKIN CANCER AND DERMATOLOGY CENTER OF COLORADO SPRINGS, P.C.

FINANCIAL POLICY AND PATIENT AGREEMENT

PAYMENT IS EXPECTED, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT CASH, CHECK, VISA, AND MASTERCARD FOR YOUR CONVENIENCE. WE REQUIRE THAT YOU READ THE FINANCIAL POLICY ENTIRELY AND SIGN PRIOR TO TREATMENT.

BIOPSY
By signing below, I understand biopsy/biopsies may be performed. Biopsies are generally billed by Skin Cancer and Dermatology Center to my insurance. In some cases, the biopsy/biopsies may be sent directly to an outside laboratory or for a second opinion. I understand the outside laboratory will bill my insurance directly and I may be liable for the additional cost incurred.

FINANCIAL AGREEMENT
The patient also authorizes the exchange of information relating to care and claims with the patient's insurance company(s), its intermediaries, carriers, referring physician, primary care physicians. The patient authorizes insurance payments to be made directly to the Practice for services provided. Payment by the insurance company sent directly to the patient must be reimbursed by the patient to the Practice. Regardless if my insurance pays for the services rendered, by signing below, I authorize and consent to examinations, treatments, and procedures which, by the assessment of my physician, may be considered necessary or advisable for diagnosis or treatment of my case. By signing below I authorize any credit amounts, regardless of the date it was paid, to be applied to any balance due on my account.

INSURANCE - The patient is responsible to make available to the Practice complete insurance information, for accurate filing of claims. Insurance information includes referrals from other providers for primary and secondary insurance coverage, all identification and benefit cards or documents. The patient agrees that if the insurance company denies benefits for any reason, that he/she is responsible for the full amount of the bill immediately. For services not covered by the patient's benefit plan, payment is **due at the time of service.**

HMO and PPO INSURANCES – If the Practice has an agreement with the patient's insurance carrier, we will accept payment from the carrier for services covered by the patient's benefit plan. Deductibles, co-insurance and co-payments are **due at the time of service** and are collected before the service is provided.
INDEMNITY-TYPE INSURANCE – Insurance payments received by the Practice will be applied to the patient's account and the patient agrees to pay the balance. Deductibles, co-insurance and co-payments are **due at the time of service** and are collected before the service is provided.
MEDICARE – The Practice accepts assignment from Medicare. Therefore, the patient agrees to pay the Practice the Medicare co-insurance including any amount of the patient's deductible that is not yet satisfied. Any procedures not covered by Medicare (i.e.: cosmetic) may be **due at the time of service.**
MEDICARE PATIENTS ONLY - If you have a supplemental policy in which the Medicare Carrier automatically sends the claim, we are required to keep a separate signature on file. I authorize the Practice to release any medical information to my supplemental insurance for determination of benefits or the benefits payable for related services.

_____ _____
Sign name as it appears on supplemental card Date

NON-CONTRACTED INSURANCE - The patient must recognize that he/she is responsible to pay the full amount, **due at time of service,** unless the Practice has an agreement with the patient's insurance carrier for alternative payments. As a courtesy, the Practice will file insurance claims with all standard insurance carriers.
TRICARE PRIME INSURANCE PATIENTS ONLY – I understand my insurance requires a prior authorization and/or referral for each visit. By initialing below, I acknowledge that I have been informed. I will need to reschedule my appointment or sign a waiver agreement accepting full financial responsibility if a referral/authorization has not been obtained for my procedure for each visit.
_____ (Patients/ Responsibility Parties Initial)

MISSED APPOINTMENT FEES/NSF FEES
Appointments that are repeatedly rescheduled or cancelled will incur a fifty-dollar ($50.00) fee that will be paid prior to rescheduling the appointment. If the appointment is kept, we will refund or apply the paid amount to any balance due. Our policy states if you reschedule, cancel, or miss more than three (3) appointments you may be subject to the rescheduling fee. We require a minimum of forty-eight (48) hours notice to reschedule for **all** procedures or twenty-four (24) hours for regular office visits. A twenty-five-dollar ($25.00) fee will be added to your account for any returned checks.

REPSONSIBLE PARTY
The responsible party will default to the primary insured policy holder. If you wish the responsible party to be someone other than the primary insurance policy holder please notify the receptionist.

I understand that I will be responsible for all fees incurred if my account is delinquent. Such accounts are subject to finance charges, collection fees (a minimum of twenty-five dollars ($25.00) to thirty-five (35) percent of balanced owed whichever is greater), and reasonable attorney fees. Special financial arrangements can only be made with an addendum to this document. Failure to notify the billing department of changes in the financial agreement or failure to pay outstanding balances could result in being turned over to collections and dismissal from the Practice.

PATIENT AGREEMENT: I have read and understand the financial policy above and agree to the terms stated above.

_____ _____
Patient's Signature/Guardian Date