FINANCIAL POLICY AND PATIENT AGREEMENT

PAYMENT IS EXPECTED, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT CASH, CHECK, AND MOST MAJOR CREDIT CARDS FOR YOUR CONVENIENCE. WE REQUIRE THAT YOU READ THE FINANCIAL POLICY ENTIRELY AND SIGN before TREATMENT.

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

BIOPSY
By signing below, I understand biopsies may be performed. Biopsies are generally billed directly by the Skin Cancer and Dermatology Center to my insurance. In some cases, the 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.

INSURANCE - The patient is responsible for making available to the Practice complete insurance information for the 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 insurance 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 provided.

INDEMNITY-TYPE INSURANCE – Insurance payment is applied directly 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 provided.

NON-CONTRACTED INSURANCE - The patient must recognize that he/she is responsible for paying the full amount **due at the 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 prior authorization and/or referral for each visit. I will need to reschedule my appointment or sign a waiver agreement accepting full financial responsibility if a referral/authorization not obtained for my procedure for each visit. By initialing below, I acknowledge that I am informed.

________________________ **(Patient/Responsible Party Initial)**

MEDICARE PATIENTS ONLY

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.**

_______________________ **(Patient/Responsible Party Initial)**

MISSED APPOINTMENT FEES/NSF FEES

Appointments repeatedly rescheduled or canceled will incur a fifty dollar ($50.00) fee to be paid before rescheduling the appointment. If the patient keeps the appointment, then the fee will be applied to any balance due or refunded. 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 added to your account for any returned checks.

COLLECTION FEES

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 (30) percent of the balance owed or whichever is higher), and reasonable attorney fees. 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/or dismissal from the Practice. An addendum to this document needs administrative approval for special financial arrangements.

FINANCIAL RESPONSIBLE PARTY

According to the Affordable Care Act, patients may be on their parent/guardian's insurance until the age of twenty-six (26). However, the responsible party will default to the patient unless the patient is under the age of eighteen (18), then it will default to the primary insured policyholder. If you wish the responsible party to be someone other than the primary insurance policyholder, please notify the patient service representative.

Additionally, statements and collection notifications are sent to the primary insured policyholder unless the patient informs the patient service representative otherwise.

COSMETIC PRODUCTS AND PROCEDURES

Products sold by the practice are subject to sales tax. Cosmetic products and procedures are not billable per insurance guidelines, and therefore payment is due at the time of service.

PATIENT AGREEMENT: I have read and understood the financial policy above and agree to the terms stated. By signing below, I agree with all the above terms and responsibilities. I authorize the Practice to release any medical or any other information necessary to process my claim to my primary, secondary, and tertiary insurance for the determination of benefits or the benefits payable for related services.

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Printed Name of Patient or Guardian **Relationship to Patient** **Date**

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Signature of Patient or Guardian **Date**