FINANCIAL POLICY AND PATIENT AGREEMENT

PAYMENT IS EXPECTED, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT CASH, CHECKS, AND MOST MAJOR CREDIT CARDS FOR YOUR CONVENIENCE. WE REQUIRE YOU TO READ THE FINANCIAL POLICY AND THE SURPRISE BILLING ACT ENTIRELY AND SIGN BEFORE TREATMENT.

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. Sometimes, 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 to file claims accurately. Insurance information includes referrals from other providers for primary and secondary insurance coverage and all identification and benefit cards or documents. The patient agrees that if the insurance company denies benefits, the patient is immediately responsible for the total amount of the bill. Payment is due at the time of service for services not covered by the patient's benefit plan**.**

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. Indemnity 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 is provided**.**

HMO INSURANCE-I understand my insurance MAY require prior authorization and/or referral for each visit. I will need to reschedule my appointment or sign a waiver agreement accepting financial responsibility if a referral/ authorization is not obtained for my procedure for each visit.

SURPRISE BALANCE BILLING DISCLOSURE FORM - Beginning January 1, 2022, per the Department of Health and Human Services (HHS), that protects you from "surprise billing," also known as "balance billing." If you are seen by a health care provider or use services in a facility or agency, not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

OUT-OF-NETWORK INSURANCE – The patient must recognize that they are responsible for paying the entire amount **due at the time of service** unless the Practice has an agreement with the patient's insurance carrier for alternative payments and/or with the patient's consent of out-of-network insurance. As a courtesy, the Practice may file insurance claims with all standard insurance carriers. Typically, an out-of-network waiver is signed by the patient, guardian, or the patient representative for any out-of-network provider or facility; therefore, you are billed accordingly based on insurance's eligible charges.

TRICARE PRIME PATIENTS – 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 Point of Service's financial responsibility if a referral/authorization is not obtained for my procedure for each visit.

MISSED APPOINTMENT FEES/NSF FEES - Our policy states if you reschedule, cancel, or miss more than three (3) appointments, you may be subject to the rescheduling fee of fifty dollars ($50.00). We require a minimum of forty-eight (48) hours notice to reschedule **all** procedures, including cosmetics, 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.

COLLECTION FEES - I understand that I must notify the billing department of changes in the financial agreement. I understand that failure to pay outstanding balances could result in being turned over to collections and/or dismissal from the Practice. 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. 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 age twenty-six (26). However, the responsible party will default to the patient unless the patient is under eighteen (18), then it will default to the primary insured policyholder. Please notify the patient service representative if you wish the responsible party to be someone other than the primary insurance policyholder. Ultimately the person who signs the financial agreement is responsible. 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 services per insurance guidelines, and therefore payment is due in full at the time of service.

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. I authorize the Practice to release any medical or other information necessary to process my claim to my primary, secondary, and tertiary insurance to determine benefits or the benefits payable for related services.

By signing below, I authorize and consent to examination, treatments, biopsies, and procedures that may be considered necessary or advisable for the diagnosis or treatment of my case by assessing my provider. Regardless of if my insurance pays for the services, I understand I am financially responsible. I authorize any credit amounts to be applied to any balance due on my account, irrespective of the date paid.

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PATIENT'S PRINTED NAME

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PRINTED NAME OF GUARDIAN/RESPONSIBILITY PARTY **IF DIFFERENT** THAN ABOVE

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SIGNATURE OF PATIENT/GUARDIAN/RESPONSIBLE PARTY DATE

☐ I **REQUESTED** A COPY OF THE SURPRISE ACT ☐ I **DECLINED** A COPY OF THE SURPRISE ACT