Patient Financial Policy

Thank you for choosing Dermatology & Skin Cancer, P.C. (DSCC) as your skin cancer health care provider. Your health and well-being is our primary concern. We offer the following information to help you understand our financial policies and aid you in planning for payment. Carefully review the information and please ask our staff if you have any questions.

Insurance

We participate with Medicare and many other commercial insurance carriers. It is your responsibility to provide us with current insurance information (primary and/or secondary) so that we can verify your benefits and eligibility. We will scan a copy of your insurance card and a photo ID (i.e. driver's license) at your first visit. We ask that you always bring your most recent insurance card with you every time you visit our office in case we need to update your chart information.

Please remember that your insurance policy is a contract between you and your insurance company. It is your responsibility to understand your plan, its coverage and physician participation. As a courtesy, we will file your claims for you, and provide factual encounter information to the insurance carrier to have the claim processed properly, but we will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, covered charges and "usual and customary" charges.

Some services may not be covered under your insurance plan. These will be identified to you prior to performing the service and you will have the opportunity to decide if you would like to have the service performed. If you decide to proceed with the service, you will be responsible for the subsequent charges and payment will be at the time of the visit. Also, please be aware that if we are out-of-network for your insurance carrier, your share of our charges is typically more than if we are in-network.

Once your insurance company has processed your claim, and DSCC has received an explanation of benefits, we will bill you for any remaining balance that is your responsibility through our billing company, Secure Health Information Management. This balance is due upon your receipt of our statement. In the event that you are unable to pay the balance in full, we encourage you to contact our office manager promptly for assistance in arranging reasonable installment payments.

Laboratory Services

Some services, such as biopsies, cultures or surgery, require specimens to be sent to a laboratory for processing. You may receive a separate bill from CBL Pathology or Health Network Laboratories for costs not covered by your insurance carrier.

Co-pays, Deductibles and Coinsurance

Co-payments may be required by your insurance plan. All co-payments **must** be paid when you check out at our front desk at the end of your appointment.

For patients who have insurance plans which have deductibles and coinsurance, please be aware that prior to any **procedure** you will be responsible for payment of any deductible or coinsurance that may apply to this specific procedure. Someone will make you aware of what type of deposit is necessary and explain this to you.

If it is deemed you have made an overpayment, we will refund any monies to you promptly.

Self-pay Accounts

Self-pay accounts are for patients without insurance coverage or for patients with insurance that request non-disclosure. It may also include patients covered by insurance plans in which DSCC does not participate. It is your responsibility to know if Dermatology and Skin Cancer Center is participating with your plan. If there is a discrepancy with our information, you will be considered self-pay until you provide information proving otherwise.

Self-pay patients are required to pay our assessed charges at the time of service and should be aware that they will receive a separate bill from a pathology lab if biopsies or cultures were performed at the visit.

If a surgery is recommended and full payment cannot be made at the time of service, we will work with you to determine a reasonable deposit and payment plan prior to the surgery date.

Past Due Accounts

If your account becomes past due, any upcoming appointments may need to be postponed until your account is made current or a monthly payment plan established. If your account has been referred to a collection agency or attorney, you must pay the balance in full, including any collection fees, before an appointment will be scheduled, and you may be required to make the same up-front payments as required of self-pay patients (as detailed above), regardless of any insurance coverage. It may also be possible that our physician will no longer be able to provide your care. In this case, you will be notified by certified mail and given adequate time to find a new medical provider.

Payment Options and Returned Checks

DSCC accepts Visa, MasterCard, Discover and American Express. Other forms of payment accepted are debit cards, checks and cash. You may be assessed a fee of $30 for a returned check. This amount will be applied to your account in addition to the insufficient funds amount. Your account may be assigned "self-pay" status, requiring up-front payments, following a returned check.
We offer an extended payment plan for patients meeting low income or financial hardship criteria. Please ask to speak with the office manager to arrange a monthly payment plan.

Referrals

For patients whose insurance plan requires a referral to see a specialist, it is your responsibility to contact your insurance company or primary care provider at least 3 business days prior to your scheduled date of service in order to obtain the required referral or prior authorization forms. Please make sure that all referrals are in our office prior to the appointment or the appointment may have to be rescheduled. Please be aware that while a referral and/or pre-authorization may be required by your insurance company, having a referral and/or pre-authorization does not guarantee payment by your insurance company. If you fail to obtain this paperwork and show up for your scheduled visit, you will have the option of rescheduling your appointment or assume full responsibility for the charges related to this visit which will be documented in writing.

Appointments

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. To best serve all our patients, we kindly ask for at least 24 hours notice if you are unable to keep an appointment.

Disability / FMLA / Other Forms

DSCC will charge a ten dollar ($10.00) fee for the completion of each form. Payment is required prior to the completion of any form. Please allow 10 to 14 days for completion of these forms.

Minors

The parent(s) or guardian(s) presenting the child for treatment is responsible for full payment and will receive the billing statements. In addition, we may pursue payment from a non-custodial parent or guardian.

Patient Authorization, Acknowledgement & Agreement

Authorization for Treatment: With your signature below, Dermatology & Skin Cancer Center, P.C. is hereby authorized to conduct examination, perform procedures as are medically required and administer treatment and medications as deemed necessary or advisable.

Authorization for Assignment of Benefits: I hereby authorize payment of health insurance benefits (and, if applicable, government benefits) directly to Dermatology & Skin Cancer Center for services furnished to me. I authorize the release of any of my healthcare information necessary to process and/or appeal my claims. I further authorize the release of my healthcare information to other healthcare providers, hospitals, and facilities involved in my treatment.

Acknowledgement of Financial Responsibility: I understand, acknowledge, and agree that I am financially responsible for my deductible, co-pay, co-insurance, and any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I further understand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals, prior approvals, and pre-authorizations.

I HAVE READ THE ABOVE PATIENT FINANCIAL POLICY AND/OR IT HAS BEEN FULLY EXPLAINED TO ME, AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS, AND THAT I AM COMPETENT TO EXECUTE IT OR THAT I AM AUTHORIZED TO EXECUTE IT ON THE PATIENT'S BEHALF.

Print Patient's Name:______________________________ Date of Birth:____________________

Signature:______________________________ Date:____________________

If Legal Representative, provide relationship to Patient: ______________________________