DERMATOLOGY ASSOCIATES, INC

Financial and Insurance Policies and Agreement Documentation

Patient Responsibilities:

Co-payments: As a provider, your insurance requires that we collect your designated co-pay. All co-pays are due at the time of your scheduled visit.

Non-Participating Insurance Plans: Full payment is due at the time of service. Any outstanding balances are your responsibility. Filing with the insurance is the responsibility of the patient.

Non-insured: Self-pay accounts exist if you have no insurance coverage. Payment in full is due at the time of service. If no insurance is given, you are assumed to be Self-Pay and therefore are expected to pay in full at your appointment. Should payment not be possible in full, please arrange with our finance department to schedule monthly payments.

Pre-authorizations: If insurance requires a referral, please contact your PCP to obtain the required referral.

Extended Payment Plans: These plans are issued based on the patient's current financial needs. Physician offices are not lending institutions. We require a minimum of $50.00 to be paid monthly or paid in full over a 10-month period (not to exceed 10 months total). Payments must be made on time as arranged by our finance department in order to keep the account current and in good standing. Missed payments are not acceptable and can lead to appointments being rescheduled as well as the delinquent account being sent to collections.

Outstanding balances: In order to schedule an appointment with Dermatology Associates, your account must be paid in full or your prearranged payment plan kept current. Omitted months' payments may render the account as not in good standing, and thus prevent you from securing an appointment. It is the responsibility of the patient or guarantor to maintain their account's good standing by making their regular monthly payments in a timely manner.

Collection Agency: Patients who have balances at the collection agency **must** pay their bill in full before they can be scheduled for a further appointment. If a patient owes over $1000.00, they must set up a meeting with our collection coordinator to arrange a payment plan. A late fee of $25.00 will be added to all accounts that go to collection as a processing fee.

Child Custody Cases: The individual that signs for services will be responsible for all outstanding charges and balances.

Returned Check Fees: Our returned check fee (for insufficient funds) is $35.00.

Methods of Payment: Accepted methods of payment are cash, personal checks, MasterCard, Visa, Discover, money orders, and Debit Cards. These payments can be made in person or over the telephone. Effective November 1st, 2020 Care Credit is no longer accepted as a method of payment.

Other: All Mohs patients who have not yet met their deductible, will need to set up a meeting with the Mohs secretary in person or via telephone by calling **540.486.4390**. Patients are responsible for all unmet deductibles and/or co-insurance charges.

If you have any questions or concerns regarding your account, please call us at **540.667.4499** between the hours of 9:00am and 4:00pm Monday through Thursday, or between 9:00am and 3:00pm on Friday.

Insurance and Financial Agreement

(Please initial on each line)

_____ I certify that the information reported with regard to insurance coverage is correct. I agree that if incorrect or incomplete information results in claims being denied that I am responsible for those charges.

_____ I authorize the release of any necessary information, including medical information, for this or any related claim, to my insurance carrier, or, in the case of Medicare Part B Benefits, to the Social Security Administration and Health Care Financing Administration.

_____ I authorize the release of any necessary information, including medical information, to my primary care physician for continuum of care.

_____ I hereby authorize Dermatology Associates, Inc.to apply for benefits on my behalf for covered services rendered and authorized payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Dermatology Associates, Inc. for services rendered.

_____ I understand that I am responsible for paying copayments, past due charges, and/or monthly payment arrangement payments at the time of the office visit.

_____ I understand and agree that I am financially responsible for charges not paid by my insurance company.

_____ I understand that delinquent accounts are forwarded collection when not paid (1) within 90 days from the date services are rendered if I have no insurance, or (2) within 60 days from when the date services are transferred to patient responsibility if I have insurance in force, and do not have a standing payment plan in place with Dermatology Associates, Inc. for the charges in question.

_____ I agree to cancel office visits 24 hours in advance and surgical visits 48 hour in advance if unable to keep a scheduled appointment. I understand there is a $50.00 charge for any office visit or cosmetic appointment not cancelled and a $75.00 - $200.00 charge for any surgery appointment not cancelled. I further understand that these charges are patient responsibility and cannot be billed to the insurance company. These charges will not be will not be written off. Balance must be paid prior to scheduling next office visit.

A copy of this authorization may be used in place of the original. This authorization may be revoked in writing by me or my insurance carrier at any time.

_____ I have read, understand, and agree to all of the foregoing terms. I have been given a copy of the Patient Responsibilities.

Signature_____ Date:_____

If not patient mark one: ❑ Parent ❑ Guardian ❑ POA ❑ *Responsible Party

Print Name:_____

*Responsible party's relationship to the patient: _____