

DERMATOLOGY, INC. FINANCIAL POLICY

Thank you for allowing Dermatology, Inc. to be your healthcare provider. Dermatology, Inc. is committed to the success of your medical treatment and care. Our practice will work with you to help fulfill your payment responsibility. We will file your primary and secondary medical claims for you. It is imperative that you provide us with current and accurate insurance information at the time of your appointment. We will scan a copy of your insurance cards at the time of your visit. If you fail to provide insurance information, you will be considered **Self Pay** and will be required to make payment arrangements at the time of service. It is important for you to understand that you have the contract with your insurance carrier and you will need to help us work with your insurance carrier to expedite the reimbursement process. **As the patient, you are responsible for any unpaid balance not contractually covered by your insurance.** You have final responsibility for payment for services provided. Your participation in the process is both essential and encouraged.

Privacy Policy: As required by law, Dermatology, Inc. maintains a privacy policy dedicated to the protection of our patient's medical information.

Medicare: Dermatology, Inc. is a participating Medicare provider, accepting assignment for Medicare Part B (Physician Services) claims. The patient is responsible for their Medicare co-insurance, deductibles and any services rendered that are not covered by Medicare.

Medicaid: Dermatology, Inc. only accepts Medicaid patients on a case by case basis, in consultation with the Primary Care Physician (PCP). Medicaid patients must submit a valid identification card at every visit. The patient is responsible for any spend down amount for services provided on dates that are not eligible for coverage. The patient is responsible for any services rendered that are not covered by Medicaid.

Managed Care Plans: In order to see a specialist, some insurance plans require a referral from the Primary Care Physician (PCP) or pre-certification before treatment can be rendered. It is the patient's responsibility to ensure we have this referral or pre-certification prior to the visit. If we do not receive the necessary referral or pre-certification, the patient will be responsible for payment or will need to reschedule their appointment. **All co-pays are due at the time of service.**

Commercial Plans: Dermatology, Inc. has established fees that are usual and customary for this healthcare service area. Every insurance carrier has their own usual and customary fee schedule; however, the patient is responsible for payment regardless of the insurance carrier's arbitrary determination of rates. **All co-pays are due at the time of service.**

Non-Covered Services: Some services we provide may be deemed not medically necessary by your insurance carrier or not a covered benefit by your specific policy, therefore, not paid by your insurance. Many cosmetic procedures we provide are not covered by insurance. The patient is responsible for payment at the time of service for all services not covered by insurance.

Laboratory Services: Some services, such as biopsies or surgery, require specimens be sent to a laboratory for processing. The patient may receive a separate bill from Mid-America Pathology Services or another laboratory. The patient is responsible for payment for all laboratory services not covered by insurance.

Self Pay: Patients who do not have insurance coverage are considered to be self pay. Self pay patients will be required to make payment arrangements prior to services being rendered.

Payment Arrangements: Dermatology, Inc. may consider payment arrangements for those patients who need assistance in meeting their account obligation. Dermatology, Inc. reserves the right to set the terms, conditions and to charge interest for any payment arrangement.

Credit Cards: Dermatology, Inc. accepts Visa and MasterCard. Other forms of payment accepted are debit cards, checks and cash. If a patient has an approved payment arrangement, monthly credit card debits are offered as an option for payment.

Returned Check Policy: Dermatology, Inc. will charge a twenty-five dollar (\$25.00) fee for each check returned by our bank for non-sufficient funds. As a courtesy, we will attempt to submit a check to our bank one additional time should the check be returned from the initial deposit.

Disability / FMLA / Other Forms: Dermatology, Inc. will charge a twenty dollar (\$20.00) fee for the completion of each form. Multiple forms are \$20.00 for each form. **Payment is required prior to the completion of any form.**

Missed Appointment Fees: Dermatology, Inc. may charge a fee for missed office visit appointments when the patient fails to give appropriate notification. A cancellation notice must be received twenty-four (24) hours in advance of the scheduled appointment. A twenty-five dollar (\$25.00) charge may be applied for failure to meet this requirement. A fifty dollar (\$50.00) charge may be applied for missed laser treatment appointments.

Late Fees: Dermatology, Inc. may charge a seven dollar and fifty cent (\$7.50) monthly billing fee for delinquent accounts that are forty-five (45) or more days past due.

Interest Fees: Dermatology, Inc. reserves the right to charge a monthly interest fee as defined by state law for delinquent accounts considered to be past due.

Collection Agencies: Should it become necessary for Dermatology, Inc. to send a patient's account to a collection agency, the patient will be responsible for any and all fees associated with the collection effort of the account, to include reasonable attorney fees, court costs, collection charges and interest.

Business Office Contact: Dermatology, Inc.'s business office can be reached at (317) 931-3939 or toll free (800) 969-5708. The fax number is (317) 921-7473. Please do not hesitate to contact the business office whenever you have a question.

PATIENT ACKNOWLEDGEMENT and AUTHORIZATIONS:

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

Authorization for Release of Information: With your signature below, Dermatology, Inc. (and/or Mid-America Pathology Services in the case of laboratory services) is hereby authorized to release a complete report of services rendered, diagnosis, findings and details of treatment and progress for the purpose of receiving payment for such services rendered. Recipients of such information may include authorized billings agents, insurance carriers, employer's workers compensation insurance company, other third party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, Professional Review Organizations or other intermediaries responsible for payment for services rendered. The release of information consent may be revoked at any time by giving written notice. If release of information is refused, the patient will be held responsible for payment of all charges for services rendered.

Authorization for Assignment of Benefits: In consideration of medical services provided, with your signature below, Dermatology, Inc. (and/or Mid-America Pathology Services in the case of laboratory services) is given all rights, title and interest to the medical reimbursement in accordance with the terms and benefits of the patient's insurance policy or other health benefit including Medicare Part B. The patient will be fully responsible for payment of any and all charges not covered by insurance.

I have read this Financial Policy and Authorizations. I understand that there is no guarantee or assurance as to the results that may be obtained from any treatment. I understand the terms and conditions outlined herein as confirmed by my signature below.

Patient Signature or Responsible Party

Date Signed

Dermatology, Inc. Witness Signature

Date Signed

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For Internal Office Use Only:

Patient's Printed Name: _____

Account #: _____ DOB: _____