FINANCIAL POLICY

(Effective 03/2023)

Please read the following financial policies for our office.

- **ALWAYS** bring your **current health insurance card** to the office.
- Please notify us at time of **check-in** of any **changes** in insurance, address, phone number, etc.
- You will be responsible for paying your **COPAYMENT** at the time of service as well as any **OUTSTANDING BALANCES** on your account. If you do not have insurance, please come prepared to pay for your visit in full.
- If you have an **HSA (Health Savings Account) or a HIGH DEDUCTIBLE PLAN** with your insurance, **you will be expected to make a minimum payment based on services provided that day.**
- After your insurance payment is received, you will receive a bill for any patient responsibility and/or an explanation of benefits from your carrier regarding your responsibility.

Copayments: We are required by all our insurance contracts to collect all copayments at the time of service. Copayments can be made in cash, by check, credit card, or debit card.

Monthly Statement: If you have a balance on your account of more than $2.00, we will send you a monthly statement. Any amount under $2.00 will be collected upon your return to the office.

Payments: Unless other arrangements are approved by us, the balance on your statement is due and payable upon receipt of the statement and is past due if not paid within 30 days of statement date. When necessary, payment plans can be arranged based on the balance on your account.

Cosmetic Services: Cosmetic Services are not covered by insurance and must be paid for on the date of service. **As of January 1, 2023, we are required to charge a 6% sales tax for these services.**

Pathology Services: We may use a third party for additional pathology services or special stains, if deemed necessary by the pathologist. You/your insurance will receive and additional bill from the lab service provider (Central States Dermatopathology Laboratory or University of Cincinnati Laboratory). We are unable to adjust these charges as they are provided by a separate entity.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect the debt. If we must refer your account to an outside collection agency, you must pay all the **collection costs** that are incurred. Your information will be reported to the collection agency and agree they may contact you at the phone number(s) you provided. You will be required to pay a deposit to schedule any future appointments and a credit card will be kept on file for future transactions.

Uninsured Patients: A patient who does not have insurance coverage is considered an uninsured patient. Our policy is to assist our patients in meeting their financial obligation to pay for services rendered in a fair and consistent manner.

Insurance: It is the responsibility of the cardholder to know what their eligibility and coverage is with their current carrier. If this is not known, the cardholder should verify coverage limitations prior to the appointment date. Our office will submit insurance claims for medically necessary services. Your cost for those services depends on your own insurance plan co-pay and deductible requirements. A co-pay for an office visit may not include additional costs for procedures. After insurance claims are filed, you will be billed for any remaining deductible and/or co-insurance balance. Cosmetic Services are not covered by insurance and must be paid in full on the date of service.

You agree to pay any portion not covered by your insurance, including your deductible, co-payments, and any services your plan determines to be "not covered" by your plan.

- **Referrals**: If your insurance requires a referral to see one of our physicians, it is your responsibility to make sure the referral is in place prior to the appointment date. **If referral is not in place, your appointment will have to be rescheduled,** since insurance companies do not accept backdated referrals.

- **Multiple Insurance**: If you have multiple insurance plans, it is your responsibility to see that they coordinate correctly. Please make sure our office always has the correct **primary** and **secondary** insurance order. Any **Coordination of Benefit (COB)** issues, i.e. the process of determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim, are the patient's responsibility. If patient does not resolve COB issue before the insurance filing limit, the balance will be due and payable by the patient.

Appointments:
CANCELLATION / NO SHOW POLICY: If you need to cancel an appointment with our office, it must be cancelled at least 24 hours in advance or there may be a $25.00 charge. If you do not show for a scheduled appointment, the same fee will be assessed.

For **SURGICAL** appointments, if you fail to cancel at least 24 hours in advance or do not show for your surgery, you will be charged $100.00.

If you have 3 or more no shows, you will be required to make a $25 deposit to schedule a future appointment. This will be applied to the cost of the visit; however, if the appointment is canceled or there is another no-show, the fee is non-refundable.

Insurance Release: This is to certify that I have been informed prior to receiving treatment that my insurance may not be liable for services rendered if any of the following conditions apply:

- I may have an unmet deductible under my health plan
- Services might not be covered under my health plan
- I may have a pre-existing condition or other diagnosis that may not be covered by my health plan
- Dermatology Associates may not participate in my health plan (e.g. Aetna)

I have read this Financial Policy as outlined above and on the front side of this page and understand that I am ultimately responsible for the charges incurred, and I request services be performed.

I understand that if I fail to make payment when due and my account becomes delinquent, it can be turned over to a collection agency for collection.

PATIENT PRINTED NAME: _____ Date of Birth_____

SIGNATURE OF PATIENT **OR** RESPONSIBLE PARTY _____

DATE OF SIGNATURE: _____ Staff Initials_____

Rev. 01/23