MD SkinCenter

PATIENT FINANCIAL POLICY

Patient Name: _____ **DOB:** _____

Thank you for choosing MD SkinCenter! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship. If you have any questions or need clarification of any of these policies, please contact our **billing office at 815-977-8518**.

Some plans may not offer participation to physicians in the area. It is ultimately your responsibility to ensure that the provider you are seeing is a participating provider with your health plan. Some plans may not cover certain services (e.g. removal of benign or non-irritated growths). Patients are responsible for payment of any non-covered services. Specific questions about coverage, benefits or payment issues can only be addressed by your insurance company. It is your responsibility to resolve those issues. Responsibility for your account ultimately rests with you.

Payment Due at the Time of Service

For your convenience, we accept cash, checks, debit, and credit cards. **A $20.00 fee will be applied to the account of each check that is returned for insufficient funds.**

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All co-payments, deductibles, co-insurance, self-pay charges, non-covered charges (considered to be cosmetic/not medically necessary by your insurance) and past due balances are due at the time of check-in. If your co-payment is based on a percentage (example: 20% of the allowed payment) and you do not have a secondary policy, please be prepared to pay the total co-payment due on the date of service.

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If you arrive without your co-payment, we may ask you to reschedule. If we learn that a co-pay was required after your visit, we will send you a statement which must be paid within 30 days of the statement date. Any balance that is greater than 30 days old is considered *past due*.

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Patient-responsible balances are due when you are checking out from your appointment.

In the event you need a surgical procedure you may request an **estimate** of your insurance required deductible and co-insurance amounts.

Appointment Cancellation & Attendance

We require at least **24 hours advance notice** if you will be unable to keep your appointment. This allows us to release your appointment time to another patient. If you arrive **more than 15 minutes late** for your appointment, you will not be seen and will be rescheduled

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Failure to show and/or failure to cancel or reschedule your appointment with at least 24 hours advance notice will be considered a No Show and charged a $50 fee. The fee is charged to the patient, not the insurance company, and must be paid before another appointment may be scheduled.

Proof of Insurance

Please bring your insurance card(s) and valid photo ID to each appointment. Failure to do so will result in your appointment being rescheduled. It is your responsibility to provide us with your current insurance information and notify us of any changes.

Laboratory Services

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If your insurance requires a specific laboratory for the processing of your lab-work, **it is your responsibility to notify the clinical staff at the time of service.**

Self-Pay Accounts

We designate accounts Self-Pay under the following circumstances: (1) patient does not have health insurance coverage (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient is seeking services that are not covered by insurance, (4) patient does not have a current, valid insurance card on file, or (5) patient does not have a valid insurance referral on file.

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Self-Pay patients will be provided with a Good Faith Estimate and will be required to pay for finalized, actual charges at the time of service. There may be additional fees for in-office procedures, such as biopsies, or fees billed by third parties for other supplies or services such as labs, x-rays or CTs.

Referrals

If you have an HMO or EPO plan or any other plan that requires a referral, **you are responsible for getting a referral from your primary care doctor**. Without the required referral, the insurance company will deny payment for services. **If you cannot obtain the referral, you will be required to pay for your visit at the time of service or be rescheduled.**

Financial Assistance

Our Practice treats patients regardless of financial status. If you experience difficulty paying your statement balances as due, please contact our billing office to discuss your options.

Our Responsibility to Report Non-Compliance

It is our obligation under many of the insurance contracts to report patients who: repeatedly refuse to pay co-payments/deductibles at time of service, or who repeatedly "no show" for scheduled appointments.

Divorce and Child Custody Cases

The parent who brings a child to the office for care is responsible for any payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. We do not honor divorce specifics (*e.g., percentage of financial responsibility).* Applicable co-payments, coinsurance and/or deductibles are due at the time of service.

Billing Payments and Refunds

If we must send you a statement, the balance is due in full within 30 days of the statement date. If you cannot pay the balance in full by the due date, you will need to contact our billing office to discuss your options.

It is your responsibility to notify the office of any change in address, phone, employment, or insurance.

If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.

On any accounts that remain unpaid for longer than 90 days, we reserve the right to report delinquent accounts to credit bureaus, transfer accounts to third party collections agencies, assess collections and/or reasonable attorney's/court costs, take other collection actions, and/or terminate you as a patient of this practice.

Initial here _____ I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments, deductibles, and co-insurance are my responsibility.

Initial here _____ I authorize my insurance benefits be paid directly to **MD SkinCenter.**

Initial here _____ I authorize **MD SkinCenter**, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

Initial here _____ I authorize **MD SkinCenter** to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

I authorize MD SkinCenter to discuss/share my personal health information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

X Patient/Guarantor Signature _____ Date: _____

I authorize **MD SkinCenter** to leave detailed messages regarding my medical care (e.g. lab results) and/or financial status:

(enter all that apply) ❑Home _____ ❑ Cell _____ ❑ Work _____

ACKNOWLEDGEMENT OF MD SKINCENTER NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have reviewed, received, or have been given the opportunity to receive a copy of **MD SkinCenter** Notice of Privacy Practices.

X Patient/Guarantor Signature _____ Date: _____