Financial Policy

Managed Care (HMO, PPO, EPO, POS, Open Choice, Managed Choice)

Thank you for choosing our practice. We want to make every experience you have with us a positive one. Over the past few years, the practice of medicine has become more complicated for physicians and patients alike.

Because of the growing complexity of the insurance business, we feel we can no longer assume that patients fully understand the relationship between the insurance company, the doctor, and themselves. In an effort to clarify this relationship, we have developed a set of guidelines regarding financial responsibility. If you have any questions, please speak with the office staff. Please recognize that the practice of medicine is not an exact science and acknowledge that there are no guarantees or assurances concerning the results of procedures. You will be asked to sign at the end of the form.

·**We will file your insurance for you if we are on your network.**

You are required to see a Primary Care Physician (PCP) under some plans in order to see a dermatologist or other specialist.

If your plan requires authorization by a PCP, you must obtain a referral letter or number **prior** to your visit.

If the referral is not obtained by the time of your visit, you may pay for the visit at the time of service and file the insurance yourself, or you may reschedule.

There are time limitations on referrals and claim filing. The referral limitations are set by your PCP and must be followed by this office. You are responsible at each visit for assuring that we have a valid referral letter or number. Some plans require that a claim be filed within 60 days or will be denied for timely manner.

·**You must present your card and identification at the time of your office visit.**

If we do not receive your insurance card before you see the doctor, that visit becomes fee for service and full payment is expected at that time.

·**Co-Payments, Deductibles and Co-Insurance:**

A co-payment is a set dollar amount you owe for each office visit. All PPO plans are subject to a deductible if a procedure is performed (office surgery, etc.). You will be asked to pay your co-payment plus any procedure fee at the time of service if your deductible has not been met for the year. Co-insurance is the amount required by some insurance carriers over and above the deductible and co-payment amounts. Typically, a co-insurance percentage is required on procedures done in the office. You will be billed for this amount should your insurance company notify us that additional payment is due from you.

·**Not Medically Necessary or Cosmetic Procedures:**

In order to keep health care costs down, all insurance companies now put restrictions on some previously covered procedures. Our office is aware of many of these not medically necessary or cosmetic procedures and will attempt to alert you to these procedures when possible. If you and the doctor decide to continue with a procedure that falls into this category, we require payment in full at the time of service. There is no reduction in fees for managed care patients when cosmetic procedures are performed, and we will not file with your insurance carrier for these services.

·**The following procedures are routinely considered not medically necessary or cosmetic:**

Your insurance carrier may not cover these services (including office visits for evaluation of these conditions)

-Removal of benign lesions (moles warts, skin tags, cherry or spider angiomas, lentigos or liver spots, cysts, milia, and seborrheic keratoses)
-Collagen treatments
-Glycolic acid or other chemical peels
--Scar revision
-Laser surgery for certain benign lesions
-Cautery for treatment of dilated blood vessels on the face
-All forms of Hair Loss
-Vitiligo

·**Laboratory and Pathology Fees:**

Many times it is necessary to obtain tissue or perform lab tests to confirm a diagnosis or to determine a course of treatment. If any tissue is removed for a pathology examination or if a laboratory test (blood work, culture, etc.) is done in our office, the actual test is usually carried out by someone else. **THIS MEANS YOU WILL RECEIVE A SEPARATE BILL FROM ANOTHER DOCTOR OR LAB FOR THESE TESTS.** We will attempt to use a lab which files directly with your insurance carrier. Some plans do not specify a particular lab to use. It is also not uncommon for insurance carriers to change laboratory or pathology services several times in one year and not notify us immediately. Therefore, you are ultimately responsible for any bill you may receive from the laboratory or pathology service used. If you receive a bill from the lab, please contact that lab directly to resolve any billing concerns. If the lab will not file your claim for you directly, please attempt to file the claim yourself and pay the lab directly for the services.

·**Forms of Payment:**

For your convenience, we accept cash, personal checks, MasterCard, Visa and Discover.

·**Estimation of Services:**

We will be happy to give you an estimate of fees when this is possible. Please, remember that only the doctor can give you an accurate estimation of the cost of a procedure since he will determine the exact procedure to be performed. We can only assure you of the exact cost of a procedure on the day of service when the doctor has determined the actual coding to be used. The estimate of our charges will not include work done by any outside lab or pathology service.

·**Returned Checks:**

There is a fee of **$40.00** for all returned checks.

·**Collection Efforts:**

We will send you **FOUR** statements regarding ***your*** balance. On the **THIRD** statement a **1.5%** service charge will be added to ***your*** balance. If you should receive a **FOURTH** statement noted ***"Final"*** the account balance will be turned over to a collection agency. We will add a **35% transaction fee** to any outstanding balance if it gets turned over to a collection agency. All fees are ***your*** responsibility.

By signing below, I am indicating that I do not have a government plan such as ***MEDICARE*** or ***MEDICAID*** or ***CHIPS*** or ***STAR***.

I have read and understand the above completely and agree to comply with the financial policies of this office. My signature authorizes this office to file my claims and assigns to this office all rights, title and interest to my medical reimbursement benefits under my insurance policy. I understand that my signature also allows this office to release information regarding my visits to my insurance carrier. **I understand that I am responsible for my bills in the event the insurance company denies any claims.**

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Signature of Patient (Parent, if patient is a minor) Date