

## ASSOCIATES IN DERMATOLOGY

### Financial Policy Agreement, Assignment of Benefits, and General Authorizations

Read this Agreement Carefully. You are agreeing to financial terms and you may request a copy.

I accept the terms of this agreement to avoid misunderstandings concerning the payment of fees for services provided to me. I understand that Associates in Dermatology employees are not authorized to make exceptions to this agreement.

Appointments. I agree to make every effort to keep my appointments and to contact the office at least 24 hours in advance if I cannot do so. **I understand that if I fail to keep more than 2 appointments without this advance notification in a one year period, I may be restricted to a time available basis and/or be required to make non-refundable prepayment for the office visit.**

Patients or Services Not Covered by Insurance. If I am not covered by a health insurance plan, or if I consent to services that are cosmetic, or receive other cash services, **I agree to pay a good faith estimate of charges prior to the time services are rendered.**

Deductibles, Copays, and Account Balances. **I agree to make full payment of deductibles, co-payments, or any balance on my account when I arrive for my appointment and prior to the time services are rendered.**

Accepted Methods of Payment. **I may pay fees via MasterCard, Visa, or cash. I understand that Associates in Dermatology does not accept checks** (except as a courtesy to patients with an established history of prompt payment to the practice). If my account is not paid in full, Associates in Dermatology may add a finance charge of 1.5% per month of the unpaid balance of the account each 30 day period thereafter and that I may avoid finance charges by paying the entire unpaid balance at the time services are rendered. If collection action is necessary, I agree to pay all costs of collection, including reasonable attorney's fees, court costs and collection agency fees associated with the collection process.

Insurance and Patient Financial Responsibility. **I understand that my health care plan is a contract between me and my plan and that I am responsible for the entire bill regardless of what my insurance pays.** Associates in Dermatology will bill my insurance company if I assign insurance benefits to Associates in Dermatology. I understand that all health care plans are not the same and may not cover the same services or all of my services or charges. I understand that full payment for my treatment remains my exclusive financial responsibility and I will promptly pay any amounts that are not paid by my insurance company/companies within a reasonable time as determined by the practice. I agree to make payment in full upon receipt of a statement from Associates in Dermatology. **I understand that Associates in Dermatology is not an agent of any insurance company and cannot make representations regarding my coverage. I understand that verification of insurance coverage is my sole responsibility. I am satisfied with my insurance plan coverage of charges, and I will pay all charges not paid by my insurance, including lab charges.**

Assignment of Benefits. **I authorize Associates in Dermatology to act as my agent to help obtain payment from my insurance companies and request and assign payment directly to Associates in Dermatology by all insurance companies with whom I have coverage or from whom benefits are or may become payable to me including settlements of judgments flowing from incidents for which I may receive treatment.**

Release of Medical Information Required for Claims. **I authorize Associates in Dermatology to release information or copies of my medical records**, including those containing information related to HIV/AIDS, sexually transmitted diseases, mental health (excluding psychotherapy notes maintained separately from my medical record), alcohol or substance abuse, and genetic testing, which are contained in my patient file **to any third party payors or their representatives for the purpose of obtaining payment for the services rendered by Associates in Dermatology.** Consistent with HIPPA regulations, any release will be limited to only those records required to obtain payment.

Insurance, Labs, and Patient Financial Responsibility. **I am fully responsible for lab charges not covered by my insurance. I understand that my insurance company may require use of a particular lab company and that Associates in Dermatology neither chooses nor is an agent of those labs.** I understand that insurance plans change lab participation frequently and it is my sole responsibility to inform Associates in Dermatology of the correct lab to use. **I understand that I am responsible for payment of any bill received from a lab, and will contact the lab directly to resolve billing questions.**



Minor Patients. **I understand that for all services rendered to minor patients, the adult accompanying the patient will be required to make any co-payment, deductible, co-insurance, or cash balance payments prior to service.**

Copies of Medical Records. If I request copies of medical records, I agree to pay \$1.00 per page for the first 25 pages of written material and \$.25 for each additional page and the actual cost of reproduction non-written materials such as x-rays or photographs. If I ask the practice to complete any forms other than insurance for which Associates in Dermatology has been assigned benefits, I agree to pay \$10.00 per form.

Patient Information and Financial Responsibility. I understand that Associates in Dermatology must systematically maintain and update patient and insurance information. I agree to complete new insurance and patient information forms at least once per year and whenever information changes. **I agree to pay a \$10 claim processing fee for any claim that is not paid due to incorrect or outdated information provided by me. I agree to pay a \$25 fee if I fail to notify the office at least 24 hours prior to a missed appointment.**

FOR MEDICARE PATIENTS. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Associates in Dermatology for any services furnished me by Associates in Dermatology I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services. I agree to execute such forms and documents as may be necessary to apply for and obtain payment.

I request that payment of authorized MEDIGAP benefits be made on my behalf to Associates In Dermatology for any services furnished to me by Associates in Dermatology I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services, to release said information in a timely manner.

MEDIGAP POLICY # \_\_\_\_\_ MEDIGAP INSURANCE CO. \_\_\_\_\_

LIFETIME SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

\_\_\_\_\_  
(A copy of this signature is valid as the original).

Note: A "Lifetime Signature" is not actually good for your lifetime. You provide a "Lifetime Signature" to avoid having to sign forms every time a claim is made to your insurance company. If your insurance company or terms change, or once per year, you may be asked to provide a new "Lifetime Signature".

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a copy of the Associates in Dermatology Notice of Privacy Practices as required by Federal Law.

Date \_\_\_\_\_ Patient/Personal Representative \_\_\_\_\_

Description of Personal Representative's Authority \_\_\_\_\_

Reason Patient/Personal Representative failed to sign: \_\_\_\_\_

Staff Signature \_\_\_\_\_



LABEL