The **DERM** Center

Financial Policy

POINT-OF-SERVICE (POS) COLLECTIONS POLICY

The DERM Center participates in POS Collections and asks **each patient to pay a portion of their services prior to checking in for their visit**. This policy applies to those that are insured and need to pay a deductible, copay, or coinsurance amount, or those who pay solely out-of-pocket. By collecting payment at point of service (POS) we are able to spend less time billing patients and more time *treating* them. Additionally, each patient has a legally bound contract with their insurance company. By enforcing our policy and collecting the patient's financial obligation, we are doing our part to enforce those terms.

OUR POLICY

INSURED PATIENTS ($100.00) Patients with annual deductibles are asked to pay **$100.00** on the day of their office visit. This payment goes toward paying down costs associated with your visit. (Copay, deductible, coinsurance.) This policy applies to each office visit until you have met your deductible, at which time we will only take payment for any required copay/coinsurance amounts. Eligibility and deductible/copay/coinsurance amounts will be verified during check in.

UNINSURED/CASH PAY PATIENTS ($179.00 + addn'l visit fees) Services must be paid IN FULL on the day of service. A down payment of **$179.00** is collected upon checking in for the visit. Additional fees associated with your diagnosis/treatment will be provided in the room prior to those additional services being rendered. Fees associated with your diagnosis/treatment will be collected in full at checkout.

SURGERIES / PROCEDURES a **30% down payment** will be required prior to scheduling any surgeries or procedures for patients that have annual deductibles that have not been met. (30% of the billable charges.) This payment is applied toward applicable deductible / copays / out of pocket expenses.

PAST DUE BALANCES must be paid in full prior to scheduling future appointments.

MINORS must be accompanied by their guarantor on their first visit and payment prior to services is required. Should the minor attend future appointments without a guardian present, payment is still required prior to being seen or the appointment will be rescheduled.

IF YOU ARE UNABLE TO MAKE THESE PAYMENTS IN FULL AT THE TIME OF YOUR VISIT, YOU WILL BE ASKED TO RESCHEDULE.

INSURANCE GUIDELINES

Your insurance is a contract between your insurance company and you. It is your responsibility to know and understand the terms, guidelines, and limitations of your plan. Deductibles, coinsurance, and copays are the responsibility of the policy holder at the time of service. It is also your responsibility to advise us of any changes in your insurance. If we are contracted with your insurance company, we will submit your claim for processing. Should they deny your claim or deem a service "not a benefit" or a "non-covered service" you will be responsible for the balance.

IN NETWORK VS OUT OF NETWORK - We participate with most major insurance companies. However, most have more than one plan for individual participants that contain varying coverage benefits. Your plan may be considered either in-network or out-of-network. It is your responsibility to understand your individual plan's coverage benefits to make sure the plan covers the services to be rendered. *We currently do NOT accept Medicaid plans.

- ***NO SURPRISES ACT OF 2022*** *- In accordance with the No Surprises Act of 2022, it is your responsibility to see participating providers within your individual plan. Should your plan not participate with The DERM Center or a provider of The DERM Center, and you receive medical services, you will be billed the Out of Network patient responsibility or non-participating balances as they pertain to services provided.*

REFERRALS - It is your responsibility to ensure we have any required referrals or pre-certifications **prior** to your visit. If we do not, you will be responsible for payment, or will need to reschedule your appointment.

BILLING GUIDELINES

We will send your claim to your insurance company for processing. We will apply payments made at the time of your visit toward this balance and any remaining balances will be mailed to you. Payment for these balances are due upon receipt.

COLLECTIONS

Outstanding accounts will be forwarded to a collection agency at the patient's expense. *Outstanding accounts will not be able to schedule appointments with The DERM Center until the balance is paid in full.*

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LABORATORY SERVICES (PATHOLOGY / LABS / SPECIMENS)

Some services, such as biopsies, procedures requiring the removal of a specimen, and bloodwork, require specimens to be sent to a laboratory for processing. You will receive a separate bill from this laboratory. **If your insurance requires the use of a specific lab, this must be clearly communicated to our staff prior to services being provided.** Because these charges are separate and generated outside of our practice, any questions about laboratory billing must be directed to the resulting agency on your bill.

PAYMENTS

The DERM Center accepts payment in the form of cash, credit/debit (not AMEX), money order, and check. **Post-dated checks will not be accepted,** and all **returned checks will incur a $50 returned check fee** and will be applied to the patient's account. Payments can be made through your patient portal, online through our website, in person, and by phone. Payment arrangements may be considered for those patients who need assistance in meeting their account obligation. (Not applicable to past due accounts.) The DERM Center reserves the right to set the terms and conditions for any payment arrangement.

MISSED APPOINTMENT FEES

We respectfully request that you provide notice if you are unable to make your appointment. We understand that unforeseen events may result in the need to cancel your appointment at the last minute. However, if you miss more than one appointment within one calendar year, the following no-show fees will be applied to your account and MUST be paid prior to rescheduled:

OFFICE VISITS: $25.00 No Show Fee
SURGERY / PROCEDURE: $75.00 No Show Fee

By signing this agreement: (Please review, initial, and sign)

_____(INITIAL) If insured AND with an annual deductible, I understand **$100.00** is due upon checking in for each of my visits and that these payments will be applied to my processed claims, toward my copay/deductible/out of pocket expenses.

_____(INITIAL) If cash pay/uninsured I understand **$179.00** is due upon checking in for each of my visits, as well as diagnosis/treatment fees that will be collected upon checking out for my visit. I understand that $179.00 is ONLY the cost of the office visit.

_____(INITIAL) I understand that more than one no show will result in a **$25.00** or **$75.00** no-show fee that will be applied to my account and will need to be paid in full prior to rescheduling my missed appointment.

_____(INITIAL) I understand that surgeries and/or procedures require a **30% down payment** prior to scheduling unless I have met my annual deductible, at which time applicable coinsurance estimates will be provided.

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to The DERM Center and The DERM Center's representatives (hereinafter, "My Authorized Representatives") and I appointment them as my authorized representative with the power to: (1) File medical claims, appeals, and grievances with the health plan and (2) Discuss/divulge any of my personal health information or that of my dependents with any third party including the health plan. I certify that the health insurance information that I provided is accurate as of the date set forth below and that I am responsible for keeping it updated. I hereby authorize My Authorized Representatives to: (1) release information necessary to my health plan (or its administrator) regarding my diagnosis and treatments; (2) process insurance claims generated in the course of treatment. I understand that refusal to sign this form will result in my appointment being canceled or rescheduled.

_____ _____
(Patient Name - PRINT) (Guarantor Name - PRINT)

_____ _____
(Patient Signature) (Guarantor Signature)

_____ _____
(DATE) (DATE)