Thank you for allowing Dermatology & Skin Cancer Specialists, PSC to be your healthcare provider. We are committed to providing you with the best possible care. We wish to avoid any misunderstandings about our billing and payment procedures, so we ask you to review this policy. If you have any questions, please do not hesitate to speak to our office staff. We may also direct your questions to our billing consultants, MDBS.

Insurance: We will be happy to process your insurance claims if you have insurance that we participate with. We must emphasize that our relationship is with you and not your insurance company. All charges are your responsibility at the time of service (this excludes any amount due from your insurance company that we have agreed to accept payments from.) Each insurance policy is individual, and it is the member's responsibility to fully understand their benefits, eligibility dates, and what is covered or not covered by their insurance. INITIALS _____

Demographic Information & Insurance Cards: It is extremely important that we have always updated demographic information as well as a current copy of your insurance card on file. If your insurance changes, it is your responsibility to let us know as soon as possible and to inform us of the effective dates of your new policy. If prior encounters need to be refiled to a different insurance, you must notify us immediately due to "timely filing" requirements by your insurance. If we do not have your updated insurance information, then your claims may be denied for "timely filing" by your insurance and those claims would become your financial responsibility. INITIALS _____

Network Providers: It is your responsibility to know if your physician is considered "in network" by your insurance. Please call your insurance to verify that you are in network and contact us if there are any questions regarding network eligibility. INITIALS _____

Co-Pays, Co-Insurance, Deductibles, HSA, HRA & Flexible Spending Accounts: I understand that any co-payments, deductibles, and co-insurances are due at the time of service. This also applies to HSA, HRA and Flexible Spending Accounts. We will collect up front an estimated allowable for the services provided. Failure to produce payment at check-in may result in your appointment being rescheduled. I understand that I am responsible for any balance not covered by insurance. INITIALS _____

Surgical Services: Co-insurance, co-pays and deductibles are due on the day that surgical services are rendered. Our office will contact your insurance company to determine the amount due and will contact you prior to your procedure to discuss this obligation. INITIALS _____

Cosmetic Services & Product Purchases: Payments for cosmetic services are due in full at the time of the service. We do require an $85.00 deposit for cosmetic services that is due at the time of scheduling your appointment. You must provide our office with 2 business days' notice to cancel a cosmetic procedure, or you may forfeit the amount of your deposit. The purchase of laser packages and skin care products are non-refundable. If you develop a reaction to a product, you may return the product within 10 days and receive a credit for the full amount which may be applied to any other cosmetic procedure or service. INITIALS _____

Annual Skin Cancer Exams: Please note that annual skin cancer exams will be subject to your deductible and/or copay. "Preventive visit" codes are most often not recognized by insurance companies for dermatology visits. INITIALS _____

Laboratory Services: Some services, such as biopsies or surgery, require specimens to be sent to a laboratory for processing. The patient may receive a separate bill from the laboratory. I understand that I am responsible for payment for all laboratory services not covered by insurance. INITIALS _____

Missed Appointment Fees: DSCS will charge a $50.00 fee for missed office visits, surgical and laser appointments when the patient fails to give appropriate notification. A cancellation notice must be received 24 business hours in advance of a scheduled office visit appointment and a cancellation notice of 48 business hours in advance is required for a surgical or laser appointment. I understand that I will be charged a $50.00 cancellation fee if I do not give proper notice. INITIALS _____

Returned Check Policy: I understand that I will be charged a $25.00 fee for any check returned by my bank for non-sufficient funds. INITIALS _____

Disability, FMLA, Medical Records, Other Forms: DSCS will charge a $25.00 fee per form which is due in advance. Should you need a copy of your medical records, a signed authorization is required. You will be provided with your first copy at no charge, after that you will be charged $25.00 for the first 50 pages, and $.10 per page for each additional page, plus any postage charges. INITIALS _____

Minor Patients: The parent or guardian accompanying a minor are responsible for providing current insurance information for the minor as well as the payment at the time of service. The parent or guardian must sign an Authorization for Medical Treatment Form anytime a minor arrives unaccompanied for an appointment. Without this completed form, we are unable to see a minor accompanied by a parent or guardian. INITIALS _____

Payments: As a courtesy to our patients, we gladly accept cash, check, Visa, Mastercard, Discover, American Express & Care Credit. Any outstanding balances more than 90 days past due will be sent to a professional collections agency and may result in dismissal from the practice. If your account is assigned to the collection agency you will be responsible for all fees associated with the collection effort of the account, to include reasonable attorney fees, court costs, collection charges and interest. I understand that my account may be turned over to a collections agency and I may be dismissed from the practice as a patient. INITIALS _____

I have ready and understand the above financial policy and understand my obligations in exchange for medical care provided by Dermatology & Skin Cancer Specialists, PSC.

Printed Name: _____

Signature: _____ Date: _____