**Miller Family Dermatology Financial Policy:**

**Copayments:** Any copayment required by your insurance will be collected prior to checking in for your appointment.

**Credit Card on File Policy:** Miller Family Dermatology is committed to making our billing process as simple and easy as possible. We require that all patients leave a credit card on file with our office. We will scan your card with a card reader which stores your card number in a PCI compliant manner. After scanning, we can only view the last 4 digits and cannot access the complete credit card number.

After your insurance processes your claim we will mail a statement for the amount that your insurance says is due. Your credit card will be charged for the outstanding balance 2 weeks from the date of the statement. If you wish to mail us a check or pay cash in person, you are welcome to do so. If you would like to pay with a different credit card we have a secure online payment portal for you to do so.

**No Show and Late Cancellation Policy**: As a courtesy, we will remind you of your appointment by calling, texting, and/or emailing you prior to your scheduled appointment date. If we cannot speak to you directly, we will leave a message for you. However, our efforts to contact you may be unsuccessful because tech sometimes fails.

An appointment is a contract of time reserved for your treatment. We reserve the right to charge $50 for regular appointments cancelled or broken without advance notice of 2 business days. We charge a $150 cancellation fee for regular surgery and $200 for Mohs surgery cancelled without providing 3 business days notice prior to the appointment. All late cancellations and no show fees will be charged automatically.

Frequent no shows and/or late cancellations may result in discharge from the practice.

**Pathology, Microbiology & Laboratory Fees**: Many diagnostic services are provided by other healthcare companies. Miller Family Dermatology does not have any contractual arrangement with them and these companies will bill you separately. Biopsies are often sent to an outside pathology lab. You will receive a separate bill from the pathology lab for this microscopic examination. Microbiology testing is performed by a separate lab that will bill you separately. If blood testing is recommended, you will be provided with a lab slip to take to the lab of your choosing. They will bill separately for their testing.

**Cosmetic Services:** The removal of benign lesions is deemed cosmetic and is not covered by insurance. There typically will be an office visit billed to insurance for the evaluation of these lesions. Cosmetic removal fees are separate from any medically necessary evaluation or treatment done at the same visit.

Lasers, botox, fillers, etc. are entirely cosmetic.

Cosmetic services cannot be billed to insurance, nor can we knowingly try to bill insurance in the hope that it may be covered. Charges for cosmetic services must be paid in full at the time of the service.

**Product Purchases**: All purchases are final. Products purchased from Miller Family Dermatology cannot be returned for credit or refund. If there is a defect with a product, it may be exchanged for the same product if the unused portion is returned to the office within 1 week of purchase.

**Patient/Parent/Guardian Responsibility**: The parent(s) or guardian(s) accompanying a minor is responsible for providing current insurance information for the minor as well as the payment for services provided. At the initial visit you may sign our consent for minor treatment form that allows us to render care at follow up visits without the presence of a parent or guardian.

**Expired/Invalid Credit Cards:** Charges to your credit card will be declined if your card expires or the bank issues you a new card. If charges are declined, we will call you to get an updated credit card. If our calls are not returned within one week, a $35 declined payment fee may be applied to your account and a new statement will be mailed. Your account becomes delinquent if not settled within 14 days.

**Returned Checks**: All returned checks will be subject to a $35 returned check fee. If the check is returned for any reason you have 7 days to contact the office and arrange another form of payment.

**Past Due Balances:** Past due balances must be paid in full before scheduling additional visits or other services.

**Delinquent Accounts:** I understand that my account becomes delinquent if not paid within 30 days after billing and the unpaid balance becomes subject to a monthly finance charge of 1.5% (18% APR) or $35, whichever is greater. All unpaid accounts, regardless of size, are turned over to collections and you will be terminated from the practice.

**Patient Name (Printed) _____ Patient DOB: _____**

**Financial Policy Acknowledgement:**

I authorize payment to be made directly to Miller Family Dermatology by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. I authorize the use of my signature below on all my insurance submissions whether manual or electronic. I acknowledge that I have read and understand this information.

I understand I will be charged for, and hereby agree to pay, all costs and expenses incurred in collecting any past due fees, and interest allowed by law, all without relief from valuation and appraisement laws.

**Preauthorization Policy:**
I consent to keeping a credit card on file with Miller Family Dermatology to be used for all unpaid balances for services rendered now and in the future. I authorize Miller Family Dermatology to charge my card in full for any outstanding balances. Charges will only be made after the claim has been adjudicated by the insurance carrier.

I understand payments for Self-Pay and/or cosmetic services are due at the time of the office visit and give permission for these charges to be placed on my credit card on file.

I am aware of the late show and late cancellation policy and give permission for these charges to be placed on my credit card on file.

**The "Miller Family Dermatology Financial Policy" has been made available to me and I understand and agree to its terms. I consent to the Preauthorization Policy and to charges to my account in accordance with that policy.**

Patient/ Guardian Signature: _____ Date: _____

Relationship of guardian to patient: _____

**Notice of Privacy Practices (HIPAA) Written Agreement and Information Release:**

I have read a copy of Miller Family Dermatology's Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request. I understand Miller Family Dermatology has a link to the Notice of Privacy Practices on the practice website located at: https://millerfamilydermatology.com

Patient/ Guardian Signature: _____ Date: _____

Relationship of guardian to patient: _____

**Authorization to release information to family members:**

I hereby authorize Miller Family Dermatology to release any information from my medical record, which will contain Protected Health Information such as clinical notes, laboratory results and biopsy results to the individual identified below. Please note that the law does not require the recipient of this information to keep it confidential.

Miller Family Dermatology is authorized to disclose my information to:

_____ Relationship to patient: _____ Telephone: _____

Patient/ Guardian Signature: _____Date: _____

Relationship of guardian to patient: _____