APPOINTMENT AND FINANCIAL POLICY

Effective 01/01/2020

Thank you for choosing us for your skin care needs. We are committed to providing you with the best possible medical care. The following is a statement of our appointment and financial policies which we require you to read and sign prior to your treatment.

OUR RESPONSIBILITY:

- To bill all claims to your primary and secondary insurance carriers in a timely manner.
- To assist you in resolving any problems with claim payment.

YOUR RESPONSIBILITY:

- To provide us with accurate information to submit your claims correctly, including copies of your insurance card(s) and photo ID.
- To make certain there is an authorization for our physicians to treat you if it is required by your insurance.
- To pay your copay at the time of service. We accept Cash, Check, Credit/Debit Card, and Care. No Post-Dated or Third-Party Checks. All returned and NSF checks will result in a $35.00 fee.
- Present a credit card, Health Savings or Flexible Spending card to be encrypted for automatic payment of your remaining copay, coinsurance, or deductible balances when they become due on your account as determined by your insurance plan.

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APPOINTMENT POLICY:

- A scheduled appointment is a commitment of time between the doctor and patient. We have reserved time just for you. When appointments are missed or canceled with short notice, that time is lost. When you've made an appointment, we request you make every effort to keep that appointment. We understand that emergencies do arise but reserve the right to charge no show or late cancellation fees.
- Missed appointments or appointments canceled without required notice will be charged as follows:
  - **$50** fee for regular appointments cancelled without advanced notice of 2 business days.
  - **$150** fee for surgery, Botox or filler treatments cancelled without advance notice of 4 business days.
  - **$200** fee for Mohs surgery cancelled without advance notice of 4 business days.
  - **Laser treatments** and other procedures are subject to no show/late cancellation fees that will be disclosed at the time of scheduling treatment.
- If you arrive late to your appointment, we will do our best to work you back into the schedule, however, you may be asked to reschedule.

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REFERRALS/AUTHORIZATIONS:

- Some insurance plans require your primary care provider to obtain a referral authorization number from the insurance company for you to see us. A referral requirement is the result of your contract with your insurance company, so it is ultimately your responsibility to ensure that it has been done.
- If your insurance company denies payment because a referral has not been obtained, you will be responsible for the cost of the visit.
- You are responsible for any balances classified as 'Patient Responsibility' by your insurance company.
- Any dispute with claim processing is between you and your insurance company.

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PAYMENT ARRANGEMENTS:

- Once your insurance processes your claim, a copy of the EOB (Explanation of Benefits) will be issued to you by your insurance. We will send a patient statement for balance due based off your finalized claim.
- In an effort to be more environmentally conscious and earth friendly we provide one paper statement via USPS.
- You may mail a check, pay in person, pay online, or allow the balance to be charged to your credit card on file.
- 28 days after the statement is sent, we will process the balance due to your credit card on file.
- If your card is declined or has expired, a second statement will be sent. Accounts not paid within 14 days of the second statement become past due and may incur a one-time $35.00 Collection Fee. The Collection Fee will be applied to your account.
- All accounts over 60-Days without an approved payment plan are subject to finance charges of 9% APR.
- Past Due Account balances must be settled prior to making or being seen for a subsequent appointment.

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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.
- The adult presenting the minor for care is the responsible party unless a written agreement signed by both parents is provided to Miller Family Dermatology.

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LABORATORY FEES: ❖ Pathology services performed in-house will be charged along with an office visit, which may be applied to your deductible along with your copay and coinsurance percentage. If further testing is required to obtain an accurate diagnosis, your specimen will be sent to an outside laboratory which will bill you and your insurance separately.	**Initial Below:** ___
COSMETIC SERVICES: ❖ All cosmetic fees are in addition to fees for any necessary medical evaluation or treatment that may occur at the same visit. ❖ The removal of most benign growths is considered cosmetic and is not covered by insurance. The office visit consult to determine if a growth is benign is billed to insurance. ❖ All Lasers, Botox, fillers, etc. procedures are considered cosmetic. ❖ MFD does not bill insurance for cosmetic procedures, nor will we try to bill insurance hoping it may be covered. Coding cosmetic treatments to "get them covered" is insurance fraud and will not be entertained. ❖ Charges for cosmetic services must be paid in full at the time of the service.	**Initial Below:** ___
COLLECTION POLICY: ❖ 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. ❖ All unpaid accounts, regardless of size, are turned over to Physician's & Dentists Credit Bureau or pursued in small claims court. ❖ Returned Checks and Chargebacks: 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. Credit Card chargebacks will be subject to a $50 administrative fee in addition to any other bank fees that are assessed. ❖ Miller Dermatology has a collection policy in place for delinquent accounts. If we have been unable to obtain payment in full or maintain scheduled payment arrangements from you after 120 days of repeated attempts, the account will be turned over to our collection agency and you will be discharged from the practice.	**Initial Below:** ___
ASSIGNMENT: ❖ 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.	**Initial Below:** ___
CREDIT CARD PREAUTHORIZATION: ❖ 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 processed 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.	**Initial Below:** ___

ACKNOWLEDGEMENT OF FINANCIAL POLICIES AND HIPAA PRIVACY POLICIES:

❖ I certify that I have read the financial and appointment policies of Miller Family Dermatology, and I agree to abide by these policies.

❖ 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 ______________________________ **PATIENT NAME PRINTED** ______________________________

Relationship of guardian to patient: ________________________ **DATE** ____/_____/______

(Parent or legal guardian must sign if patient is under 18)