DERMATOLOGY ASSOCIATES

Patient Financial Responsibility Policy

1. What is a Co-Pay?

A co-pay is the set amount you must pay per visit when you access medical care. This requirement and amount are set by your individual health insurance plan.

2. What is a Deductible/Coinsurance?

A deductible is the amount of money that you must personally pay before your insurance carrier will reimburse the practice for any amount. Once this has amount has been met on an annual basis by you, your insurance company will begin cost-sharing for covered services.

A coinsurance is a percentage amount shared between you and your insurance company. Once you meet your deductible, your insurance company then shares the cost of your claims at the specified percentage amount. For example, your insurance company may pay 80%, while you are responsible for the remaining 20%.

3. Why do I have to pay my Co-Pay, Deductible, and/or Coinsurance?

When you sign up with an insurance carrier and accept a particular benefit plan, you enter a contract with that carrier which stipulates your specific obligations (e.g., to pay your co-pay, deductible, and/or coinsurance based on your benefits). That means you are required to pay your co-pay or deductible/coinsurance for all office visits, follow-up examinations, surgical procedures, etc.

4. Why do you collect the co-pay/deductible/coinsurance?

Co-pays are always due at the time of service. Deductibles and coinsurances are billed once claims are processed per our contract with your insurance. This rule is based on our agreement with your insurance carrier and is neither negotiable nor changeable.

5. Credits and Refunds

If after all outstanding insurance claims have processed, paid, and you are due a refund, Dermatology Associates will mail you a refund check of receipt (unless instructed otherwise). If this refund is $10.00 or less, it will be applied as a credit on your account and used for future use.

6. Coordination of Benefits

It is your responsibility to supply the Dermatology Associates with all insurance cards for the coordination of benefits between all your carriers. If you fail to do so, you assume all financial responsibility for unpaid insurance claims.

7. Outstanding and Past-Due Balances

Dermatology Associates reserves the right to withhold rescheduling any patient for a follow-up appointment with an outstanding balance. In order to schedule a follow-up appointment, Dermatology Associates' staff may request that you pay, at a minimum, the outstanding balance. Or, if the account is past due, it is the patient's responsibility to make arrangements with the collection agency before being seen.

8. Self-Pay

If I am a self-pay patient or my dependent is a self-pay patient, I understand that I am responsible for an up-front payment of $100.00 at the time of check-in that will go toward my visit. I understand that I am responsible for any additional charges related to the services provided.

9. Cancellations and No-Shows

Due to the volume of individuals in the community in need of dermatologic treatment and care, Dermatology Associates respectfully requests patients provide notice of cancellation for any clinic appointments no less than 24 hours in advance and no less the 72 hours for any surgical appointments.

Dermatology Associates reserves the right to charge a no-show or cancellation fee, outside of the guidelines above, of $50 for more than two no-shows or cancellations within 24 hours and within any 24-month period. We appreciate your cooperation in ensuring we are able to see and treat as many patients as possible within our community.

In addition, patients please understand that any no-shows or cancellations may result in a significant delay to any rescheduled appointments.

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance and assign directly to Dermatology Associates, all insurance benefits, if any, payable for services rendered. I have provided all current and active insurance cards.

I further understand and agree that I am personally responsible to pay all charges that are not covered by my insurance, including but not limited to co-pays, deductibles, non-covered services and cash pay services.

I further understand I am responsible for any collection and or legal fees incurred in the collection of any past due charges.

I hereby authorize the doctors to release all information necessary to secure benefits, to continue medical care or to forward to a collection service. I authorize the use of this signature on all insurance submissions.