PRACTICE POLICIES

This document provides you with the Practice Policies utilized by Skin Dermatology. Your signature is required on this form in order to be seen by any of our providers. If you have any questions or need explanations, please ask a Skin Dermatology Team Member.

Consent to Pay for Services Rendered: Payment is required for all services at the time the services are rendered. Our practice accepts Medicare and many commercial insurance plans. Medicare will forward claims to most secondary payers. If we are contracted providers (in-network) with your insurance plan, we are required by contract with your insurance company, to collect your co-payment(s)/co-insurance and any unmet deductible at the time of service. For patients with private insurance with whom we have no contract (out-of-network), you will be required to pay for your services at the time of service. It is your responsibility to verify with your insurance plan if we are a contracted provider, if you require a referral and to understand your coverage benefits under your policy. Insurance coverage is not a guarantee of payment by your insurance company. If your insurance company fails to respond or does not pay promptly, we will forward the balance to you for payment. Should your insurance company pay after you have already paid us, we will promptly refund you any overpayment due to you. We accept all major credit cards for your convenience. If you have a bonafide hardship, please ask to speak to a patient account representative, so that we may work with you.

Consent to Communication: Skin Dermatology utilizes a number of methods to communicate with our patients. We utilize your personal information, the name of your care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying you of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. We may also utilize these communication methods to update you on the practice, inform you of any openings, send you promotional specials and/or any other practice information that is beneficial to you as the patient. You have the right to opt-out of any of these messages at any time either through the opt-out link on the message or proving Skin Dermatology written notice.

Please read and ensure you fully understand the following specifics regarding our processes.

- I understand I will be responsible for any remaining balance not covered by my commercial insurance company, Medicare and/or my supplemental policy. This also includes cosmetic services not covered by insurance. Please contact your insurance company for this information.
- All patients are required to give at least 24 hours advanced notice when cancelling an appointment. A missed appointment is defined as any appointment for which a patient does not arrive for as scheduled ("no show"), or is cancelled without a minimum of 24 hours notice (same day cancellation). Failure to give 24 hours notice ("Same Day Cancellation") or giving no notice at all ("No Show") will result in a penalty. The first missed appointment will result in a written

notice, subsequent missed appointments will result in a fee of $50 and possible dismissal from Skin Dermatology. Patients with an outstanding balance of missed appointment fees will NOT be allowed to schedule another dermatology appointment until balance is paid in full.

- I understand that procedures performed in the office are often separate billable services that are not included in the office visit. I understand that many insurance companies apply these procedures to a deductible or co-insurance and may not be covered under the co-payment. I will be responsible for any unmet deductible or co-insurance at the time of service. It is my responsibility to know and understand what my policy benefits are with my insurance company.
- I understand that if I have a surgical procedure or biopsy done at Skin Dermatology, there are two charges. First is the provider charge for collecting the Biopsy and the second is a charge to examine the specimen by a Pathologist, chosen by my attending Physician. Because Pathologists are also medical doctors, I will be billed separately for these pathology charges by the Pathologist who does the reading.
- I understand that my insurance company may have a preferred laboratory for blood work. It is my responsibility to know which preferred laboratory company I need to use. It is my responsibility also to inform my provider of this at the time services are rendered.
- The parent(s) or guardian(s) of a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Unaccompanied minors must have authorization for medical treatment signed by a parent or guardian who is responsible for current insurance information and/or payment in full for services provided.
- We refer delinquent accounts to an outside collection agency. If it became necessary to refer your account to a collection agency a collection fee of up to 30% of your balance due plus an administrative service fee of $25 will be assessed to your account. In addition, you would no longer be able to make appointments for yourself or your immediate family members until such amounts have been paid in full.
- I understand that my listed phone information will be used for collection efforts in any capacity including initiated by an autodialing system and that at a later date I can opt out.
- I understand that a $25 returned check fee will be assessed to my account for any checks returned by my financial institution. I also understand that payment of the check and fee will be due immediately and I will no longer be able to issue a check as payment to the practice.
- I understand that by supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize Skin Dermatology and/or a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third

parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

I have read the above stated policies and agree to meet my obligations in accordance with this policy. Your signature below signifies your understanding and willingness to comply with this policy.

Client*:_____ Date _____

Print Name:_____

* Parent or legal guardian if patient is under age 18 or unable to authorize consent.