Patient Name:
DOB:
MRN:

Date of Visit: ________________

Acknowledgement of Office Policies

Financial Policy Notice

FINANCIAL POLICY NOTICE

Name:
Date of Birth:

Thank you for choosing ("the Practice"). Please understand that the services you elect to participate in imply a financial responsibility on your part and you are ultimately responsible for payment of your bill. Our prices are representative of the usual and customary charges for our area. If you have any financial questions about your visit, please contact our billing department as soon as possible. We strongly encourage each patient to contact their insurer directly prior to receiving services to ensure that they fully understand their benefits and coverage. We accept cash, checks, MasterCard, Visa, Discover, American Express, and CareCredit (only available at participating locations).

ACKNOWLEDGEMENT OF FINANCIAL POLICIES

Please review and sign after reading all Financial Policies listed below:

Private Pay (Self-Pay): I understand that if I do not have health insurance, full payment is due at the time of service. In some instances, payment plans may be approved at the sole discretion of the Practice.

No Insurance: I understand that if I have no insurance, I will be required to pay for my visit in full. NOTE: there may be additional charges to your office visit if procedures are performed. In some instances, payment plans may be implemented at the sole discretion of the Practice.

Proof of Insurance: I understand that all patients must complete the Practice patient information form before seeing the provider. The Practice must obtain a copy of my photo ID and current valid health insurance card to evidence proof of insurance. I understand if I fail to provide the Practice with the correct insurance information in a timely manner, I will be responsible for the balance of the claim.

Changes in Coverage: I understand that if my insurance changes, I will notify the Practice before my next visit so they can make the appropriate changes to help me receive my maximum benefits.

Policy Benefits / Non-Covered Services: The physicians and providers of the Practice are specialists, not primary care providers, and the dermatology services provided are billed under specialist copay, coinsurance and/or deductible guidelines. The Practice does not bill for preventive services. Annual skin checks are not considered preventative services and cannot be billed as such. I understand that some or all of the services I receive may be non- covered or not considered reasonable or medically necessary by Medicare, commercial insurances, or other insurers. For services that will not be paid by my insurance company, I understand I will be required to pay for the services in full at the time of my visit. I understand it is my responsibility to know my insurance policy coverage and benefits and to notify the Practice of any insurance changes in a timely manner. Many insurance companies have additional stipulations that may affect my coverage. I understand that I am personally responsible for any amounts not covered by my insurer. Routine in-office procedures, including but not limited to, biopsies, injections, destruction of precancerous and non-cancerous growths, surgical removal and repair of cancerous and non-cancerous growths, and Mohs surgery are billed separately from my office visit and may be subject to my deductible or coinsurance. I agree to fulfill all policy provisions which my insurance companies may require for payment.

Co-payments: I understand that all co-payments are due at the time of my appointment and before I see the provider. Given that the Practice physicians are specialists, a higher co-payment may be required. I understand that failure to collect co-payments from patients may violate the terms of federal, state or commercial payor agreements. I will help the Practice uphold the obligations of my insurance payor contract by paying my co-payment at each visit.

Deductibles: I understand that if it is determined that my insurance policy has an unmet deductible, payment for services at the contracted rate between the Practice and my insurer will be due at the time of service. I understand that failure to collect any deductibles due from patients may violate federal, state or commercial payor agreements. I will help the Practice uphold the obligations of my insurance payor contract by paying my deductible at each visit.

No Show/Cancellation: I understand that if I do not cancel my appointment at least 24 hours in advance, or if I fail to appear for my appointment, The Practice will assess a **$50 cancellation/no show appointment fee**. Aesthetic or surgical appointments scheduled require a 48 hours' notice of cancellation and will be charged a **$100 fee for failure to provide 48 hours' notice of cancellation**. Administrative fees incurred for failure to provide notice or cancellation are not billable to insurance or any other third-party payor. Therefore, I understand that I will be responsible for the entire amount of the no-show/cancellation fee. No-show/cancellation fees do not apply to patients with government related insurance companies like Medicaid, Medi-Cal, or AHCCCS.

Referrals: I understand it is my responsibility to obtain any and all necessary referrals, including referrals for follow-up visits if my insurance plan requires them. It is my responsibility to obtain all referrals prior to my appointment. The Practice will strive to keep me informed of visits remaining on a referral and/or the expiration date, but it is ultimately my responsibility to know this information and to make the necessary arrangements through my primary care physician. I understand that failure to obtain a referral, if required by my insurance for coverage, will result in me bearing complete financial responsibility for any and all services received.

Benefit Representation: I understand that the staff of the Practice will make every effort to accurately verify my insurance benefits, but I will not solely rely on this preliminary verification as a basis for making financial decisions regarding treatment. I understand that I have a right to refuse any and all services before they are rendered if I think they are non-covered services or non-payable by my insurance. I understand that the final determination regarding my benefits and any amounts owed will be made by my insurer at the time of claim processing according to the provisions of the policy contract that I have with them.

Assignment of Benefits: I understand I must provide a copy of my current insurance card in order to file an insurance claim. I assign directly to the providers at the Practice all insurance benefits, if any, otherwise payable to me for services rendered. If a Medicare patient, I request that payment of authorized benefits be made on my behalf. If I am insured by a commercial insurance, I understand that I am financially responsible for all charges whether or not paid by insurance. If I am insured by a commercial insurance, I further agree to pay for any items or services not covered by insurance, as applicable. I hereby authorize the Practice to release all information necessary to secure all payments or approvals of benefits.

Payment for Ancillary Services (Laboratory/Pathology): I understand that the Practice utilizes the services of outside laboratories for pathology (biopsies), microbiology (cultures), and blood chemistry. These laboratories will bill for services separately from the Practice. I acknowledge that payments made to the Practice are for services rendered by the Practice and authorize the use of outside laboratories as deemed necessary and warranted by my doctor(s). I understand that this may result in a financial responsibility to the laboratory providing these diagnostic services.

Claims Submission: I understand that the Practice will submit claims on my behalf and assist me in any way it reasonably can to help get my claims paid. I understand that my insurance company may need me to supply certain information directly. It is my responsibility to comply with their request. My insurance benefit is a contract between me and my insurance company.

Worker's Compensation: I understand that the Practice typically does not accept Worker's Compensation cases. Exceptions will be determined solely the Practice. .

Returned Checks: I understand that checks presented to the Practice as payment for services rendered and subsequently returned by my bank for any reason as unpaid will be charged a returned check **fee of $25.** Balances must be handled by cash, credit card or money order. The Practice reserves the right to represent returned checks electronically for their face value plus the returned check fee.

Past Due Accounts: I understand that the Practice will refer all outstanding accounts to collections, consistent with Practice collection threshold policies. The Practice reserves the right to change Practice policy for collection

thresholds at any time. In the event of an outstanding balance. I acknowledge that I must contact the Practice to make payment arrangements to avoid collection.

Account Balances: I understand that for any accounts with credit balances, The Practice will make every effort to refund amounts due back to me as they are identified.

AUTHORIZATION TO ENROLL IN AUTOMATIC PAYMENTS FOR PATIENT ACCOUNT

Credit Card on File: If I accept (or decline), my signature below indicates I am given the option to enroll in Automatic Payments, ("Service Provider") charge the debit or credit card I have designated or electronically debit my bank account for a payment by me of up to $200.00 upon determination of my balance by Service Provider. "Service Provider" means and all its affiliated and related organizations. This authorization applies to each charge by Service Provider to me for balances effective after the date of this authorization that is less than or equal to $200.00.

IMPORTANT: If paying for healthcare services rendered, the following consent applies. The following does not apply to the payment of health insurance premiums.

This authorization applies to 's patient accounts billed to me and the balances that I owe under each of those patient accounts. A patient account is a financial obligation as a result of a visit to enter for dermatology and plastic surgery. I understand that may create multiple patient accounts for me as a result of a single visit to , and that multiple patient accounts may be listed on a single statement I receive in the mail. For example, a single dermatological service visit may result in one statement mailed to me with two patient accounts and charges of up to $200.00 against each patient account under this authorization: one charge of up to $200.00 for the facility usage and another charge of up to $200.00 for a radiologist to interpret the test.

This authorization is in effect until I terminate it. In addition, this authorization will terminate automatically if ceases to do business with its current payment processor, Phreesia, or for the reason described below. I understand that I have the right to terminate or modify this authorization, including updating my payment method, or discontinuing automatic payments by notifying in writing to ’s postal address. I understand that the termination of this authorization in no way relieves me of the obligation to fulfill my obligations to . My request to terminate this authorization must be received at least two (2) business days before my next payment.

If your payment is declined for any reason, including due to incorrect card or bank account information, expired information or insufficient funds, your payment will not be processed, and this authorization will be terminated. I understand that if my payment is not processed, I am still obligated to pay the applicable amount to .

I authorize my debit / credit card issuer and / or financial institution (bank) to honor transactions processed by this authorization. I certify that I am an owner of or authorized signer for the debit / credit card or the designated bank account. I acknowledge that a transaction involving a debit from my bank account is subject to the Rules and Operating Guidelines of the National Automated Clearing House Association and charge to my card is subject to the card brand rules and any agreement between me and my card issuer.

I understand that I should read this authorization carefully and keep a copy for my records. To receive a copy of this authorization for no charge I may contact my Service Provider at the address or phone number provided above.

I can change my contact information by contacting my Service Provider using the information provided above.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept all of the above policies.

☐ I Accept
☐ I Decline

Signature:

Financial Policy Notice

Acknowledgement of Office Policies

ACKNOWLEDGEMENT OF OFFICE POLICIES

Name:
Date of Birth:

Please review and sign after reading all Office Policies listed below:

General Patient Authorization: I hereby authorize providers of (The "Practice") to render care to me during my office visits and to fulfill the orders of my physicians, including consultants, associates, and assistants of the physicians' choice.

Receipt of Notice of Privacy Practices: The Notice of Privacy Practices provides information about how the Practice may use and disclose protected health information about me. The Notice of Privacy Practices contains a Patient Rights section describing my rights under the law. I acknowledge that I have had the opportunity to review the Notice of Privacy Practices. the Practice reserves the unilateral right to change the Notice of Privacy Practices.

Release of Medical Information:
I authorize the Practice and its designated representatives to release my medical information to my primary care physician.

I understand that should I need a copy of my medical records, the Practice requires a written release to be signed and dated. The form is available at the Practice's front desk and can be requested by email. It may take up to 15 business days to complete my request. If my request is urgent, I will mark the request as urgent and someone from the Practice staff will contact me to expedite the request. Absent providing a secure fax number, records must be MAILED to my address of record understand that I may also submit a request electronically to Sharecare by registering for an account at https://www.sharecare.com/. Once logged in, I will select "Submit Request" from the menu options and enter all required fields to submit an authorization to Sharecare directly. Sharecare will process my medical record request and provide notification via mail or email once complete. A complimentary copy of my record will be made available for download through Sharecare's website.

The Practice requires a written records release form to transmit records to any physician or medical organization that is not listed as my referring physician. I understand that I must request and complete a release form for each additional physician to whom my records should be sent.

Contact Permission: In the event that the Practice needs to contact me regarding an appointment, lab result, medication, or any other reason, it is permissible to leave a message on an answering machine/voicemail system or speak with other authorized individuals listed below:

Name: **Relationship:**

Name: **Relationship:**

Name: **Relationship:**

Expiration Of and Right to Revoke Authorization to Disclose Protected Health Information: I understand that I can withdraw my permission set forth above at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "Release of Medical Information" and "Contact Permission". I understand that prior actions taken in reliance on this authorization by entities that had permission to access my

health information will not be affected.

Physician Assistant, Nurse Practitioner, & Esthetician Information: The Practice may staff physician assistants, nurse practitioners, and estheticians to assist in the delivery of medical dermatology care. A physician assistant ("PA") is not a doctor but is a graduate of a certified training program and is licensed by the applicable state professional state licensing Board. Under the supervision of a physician, a PA can diagnose, treat, and monitor common acute and chronic diseases. Supervision does not require the constant physical presence of a supervising physician, but rather overseeing their work. In collaboration with a physician, nurse practitioners can diagnose, treat, and monitor common acute and chronic diseases. Estheticians provide services as directed by a PA, nurse practitioner, or physician. I understand that at any time I can request to see a physician. I have read the above and hereby consent to the services of a PA, nurse practitioner, or esthetician for my health care needs.

Proof of Identity: The Practice requires proof of identity on file. I understand that I will be asked to provide a photo ID such as a driver's license at check-in, which will be scanned into my private medical record.

By signing this Acknowledgement of Office Policies you acknowledge that you have read, understand, and accept the above policies.

By signing this form I consent to be treated at (The Practice):

☐ I Accept
☐ I Decline Signature: