SUMMIT DERMATOLOGY FINANCIAL POLICY

Patient Name (print):_____ DOB:_____Account #: _____

Parent or Legal Guardian of Patient (print):_____
(Parent or Legal Guardian financially responsible for payment)

Thank you for choosing Summit Dermatology, P.C., to serve your dermatologic needs. We are committed to building a successful provider-patient relationship, as well as providing the necessary information that we believe will be helpful and prevent any misunderstanding in the future. The following represents our policy relative to payment of services.

Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments, deductibles and co-insurance: All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, deductibles and co-insurance from patients can be considered fraud. Please help us in upholding the law by paying co-payments at each visit.

Self-Pay Services: Self Pay patients will receive a 10% discount across the board for professional services rendered, when payment is made in full at the time services are rendered. Please ask to see our Billing Representative.

Non-covered Services: Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. Biopsies, excisions or removals of any type done in this office are sent to a dermatopathologist for testing and associated charges are separate from the charges incurred in this office, and are your responsibility. We will use the pathologist specified by your insurance to the best of our ability, however, we may find it necessary to go out of network for you to receive the best medical testing and diagnosis possible.

Referral and Pre-authorization: It is your responsibility to ensure that any referrals or pre-authorizations required by your insurance carrier be provided to our office prior to services being rendered. Failure to obtain required referrals or pre- authorizations will result in you being responsible for the full balance.

Proof of Insurance and Government Approved ID: All patients must complete our patient information form before seeing the doctor. A current and valid insurance card and Government issued ID card must be presented at the time of service. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. We are not part of that contract.

Coverage Changes: If your insurance changes, please notify our Billing Representative immediately so we can make the appropriate changes to help you receive your maximum benefits.

Payment: All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with our Billing Representative. Patients may pay by cash, money order, check or personal credit card, which can include credit cards to pay from your "flexible spending account" and/or "health savings account". Should your check be returned to us for insufficient funds, we will attach a $25 service fee to your account and all subsequent visits will be on a "cash or credit card" basis.

Nonpayment: All balances are the responsibility of the patient/parent/guardian. If you are unable to meet your financial obligation, payment arrangements can be made by contacting our Billing Representative. Accounts become delinquent after 90 days. ***The account will be sent to a collection agency after we have mailed out to you three (3) statements; one (1) "Final Notice" letter as well as a courtesy phone call in our attempt to resolve your delinquent account.*** Collection fees of $50 will be automatically charged on your account once submitted to the collection agency due to our time and effort. All collection accounts must be paid in full before future care in our office will be permitted.

Minor Patients: The accompanying parent or legal guardian of the minor child receiving treatment will be responsible for payment. You will be considered the minor's "responsible party" for all services rendered and payment.

Our commitment to you as our patient is to provide excellent service and will do our best to file your claim in a timely and professional manner. Signing below signifies your understanding of the Financial Policy and your willingness to comply to the current and future services provided by Summit Dermatology. I acknowledge that Summit Dermatology may change these terms without notice to me.

Signature:_____ Date:_____
(Patient/ Parent/ Legal Guardian financially responsible for payment)