

RIVERCHASE DERMATOLOGY FINANCIAL POLICY

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we offer the following information regarding our insurance and financial policies.

Your insurance is a contract between your insurer and you. It is your responsibility to know and understand the terms, guidelines and limitations of your plan. It is also your responsibility to advise us of any changes in your insurance, your address or your employer.

Medicare & Contracted Insurance Plans

If you are on traditional Medicare or are a member of a health plan that we participate with, we will submit your claim to your insurance company. Our staff will verify your benefits and collect any copay, co-insurance and/or deductible at the time services are rendered as required by your insurance carrier. You will be billed in full for any services that your health plan deems as “not a benefit” or a “non-covered service”.

Secondary/Supplemental Insurance Plans

We are happy to file secondary and supplemental claims as a courtesy. In the case of non-contracted secondary carriers, the balance will become patient responsibility 30 days after that claim is filed.

Non-Contracted Commercial Insurance Plans

If we do not participate with your insurance carrier, payment in full will be required by you at the time services are rendered. Our billing department will file a claim to your insurance company as a courtesy to you.

Medicare Replacement Plans

We will accept and file all PFFS (Private Fee for Service) plans. Patients are responsible for all deductibles, coinsurances and copays. For all other plans see contracted and non-contracted insurance plans above.

Medicaid

We are not contracted with any Medicaid plan. Medicaid patients seeking services are responsible for payment in full at the time of service.

Minors

A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. If this is a custodial parent, we can submit the charges to another parent's insurance, however, the parent presenting the child for care will be billed for the balance not covered by the insurance. Any patient over the age of 18 will be held financially responsible for all charges incurred.

Missed Appointments

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations must be made 24 hours in advance of the scheduled appointment or we reserve the right to assess a fee.

Collection Fees

Statements are sent out monthly for patients with personal balances. Payment is due upon receipt of the statement. If you are unable to pay the balance in full, please contact our billing department at (239) 313-2517. Personal balances over 90 days from the date of service will be sent to our collection agency. In the event an account is turned over to an outside collection agency, patients will be responsible for any collection fees including court costs, attorney fees and collection agency charges.

Returned Check Fee

A \$25 fee will be added to your account balance in addition to the amount of the check returned for insufficient funds. This total must be paid in cash within 14 days.

Pathology Fees

Riverchase Dermatology has an on-site lab and pathologist who perform the slide preparation and interpretation of our patients' biopsy specimens. Fees associated with this service are separate from the procedure performed by your treating provider.

Depending upon specific factors, your provider may send the specimen to an outside lab for slide processing and interpretation. In those instances, patients or their insurance will receive a bill from the outside lab.

Riverchase Dermatology providers reserve the right to send their patient's t specimens to the most qualified dermatopathologist of his or her choosing. Therefore, **if your insurance requires the use of a specific lab, it is your responsibility to provide us with that information prior to being seen.**

Cosmetic Services

Patients are financially responsible for all cosmetic procedures at the time of service. This office does not bill insurance companies for cosmetic procedures. For more detailed information, please see one of our cosmetic coordinators.

My signature below indicates that I have read, understand and will comply with the information contained within this financial policy. A copy of this policy is available upon request.

_____ **(Signature of Patient or Guardian)**

_____ **Date**

SIGNED COPY TO CHART

Staff Initials _____ **Date** _____