PINE BELT DERMATOLOGY & SKIN CANCER CENTER

Financial Policy

We would like to thank you for choosing **Pine Belt Dermatology & Skin Cancer Center** for all your dermatologic needs. **Pine Belt Dermatology & Skin Cancer Center** is committed to providing you with the best possible medical care. The following outlines your financial responsibilities related to payment for professional services.

No Show Fee:

Please kindly give a 48 hour notice if you are unable to keep your follow up appointment. Our office reserves the right to charge your account **$20.00** in the event you do not show for your scheduled appointment.

No Show Surgical Appointment Fee:

Please kindly give a 48 hour notice if you are unable to keep a surgical appointment. Please note there will be a fee in the amount of **$100.00** added to your account in the event you do not show for your surgical appointment.

For Our Patients with Medical Insurance Benefits:

We participate in most major health plans. We have contracts with many HMO's, PPO's Insurance companies and government agencies including Medicare and Medicaid. Our business office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way reasonable we can to get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance we will automatically file a claim with them as soon as the primary carrier has paid.

Please bring your insurance card(s) and a picture identification with you at the time of your appointment. If you are a member of a plan we do not participate in, you will be a self-pay patient and a minimum of $50.00 must be paid at the time of service.

Co-Payments:

Your insurance company required us to collect co-payments at the time of service. Waiver of co-payments constitutes fraud under state and federal law. For your convenience, we accept cash, checks or the following credit cards: Visa, Mastercard, Discover, American Express and Care Credit.

Additionally, you may have coinsurance and/or deductibles, or other financial responsibility required by your insurance carrier. Any outstanding balance on your account, after adjusting for all of your insurance responsibilities, will be billed to you.

Waiver of Patient Responsibility:

It is the policy of the practice to treat all patients in an equitable fashion related to patient balances. The practice will not waive, fail to collect or discount co-payments, co-insurance, deductibles or other patient responsibility in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the practice's Charity/Free Care Policy.

Surgery Sliding Scale for those Patient's needing Financial Assistance:

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In the event you need assistance paying for a surgery that has been discussed with your provider, our office has set up the following guidelines in order to be able to legally assist our patients who may not have the means to cover their services entirely. Please ask for an application and the sliding scale information from the receptionist. The sliding scale can also be found at: (http://aspe.hhs.gov/poverty).

Non-Covered and Out of Network Services:

Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

For Our Patients with No Medical insurance:

If you do not have group or individual medical insurance, we do offer a self- pay rate. A minimum of $50.00 will be required on office visits and $100.00 on surgical procedures.

Payment Plan:

Please let us know if you are having difficulty paying your account. We are more than willing to make arrangements that will fit your budget.

Delinquent Balance Appointment:

If you have a balance more than 120 days old, you will be required to pay an additional amount towards the outstanding balance and a payment plan must be set up.

Non Payment:

All patient responsible balances that remain delinquent after 90 days, with no response to our requests for payment, may be referred to a collection agency.

Collection Agency Fees:

All patients balances that require placement with an outside collection agency will be assessed an additional fee on the account.
The fee will be as follows:
$40.00 to $100.00= $25.00 collection fee
$101.00 to $250.00= $50.00 collection fee
$251.00 plus+ $75.00 collection fee

Return Check Fee:

There will be a charge of $25.00 for any checks returned from our financial institution back to the office for non-payment. In the even we receive more than two returned checks, you will need to pay for services via cash or credit card.

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Cosmetic Services:

Services for cosmetic procedures or any service deem non-medically necessary by the provider, are required to be paid in full at the time of service.

Thank you for your understanding of our financial policy and if you have any questions or concerns, please ask for assistance.

Date: _____

Patient Name: _____

Patient and/or Responsible Party Signature:
_____

Revised 05/15/2017 jlm