Dermatology of Boca

Dr. Jeffrey Fromowitz/ Stefanie Gold PA-C

Financial Policy for Pre-Authorized Insurance Based Surgical Procedures

Thank you for choosing Dermatology of Boca for your care. We will provide medical services to you provided that you understand and comply with the following financial policies of our practice. If you have any questions about the following, please ask to speak to our front office billing staff or office manager.

Submission of Insurance Claims

Your health insurance policy is a contract between *you* and *your health insurance plan*. You are responsible for understanding and following your plan's required policies and procedures and for providing us with accurate and up-to-date insurance information so that we can file insurance claims on your behalf for any services rendered. If we do not receive payment within 60 days from the date the claim was filed with your health plan, you are responsible for any unpaid balance and we may request immediate payment from you. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. It is your responsibility to contact your health plan regarding benefits or coverage issues.

Referrals and Prior Authorization

If your health plan requires you to have a referral authorization from your primary care physician in order to be seen by our practice, it is your responsibility to verify that a referral has been received by our office prior to your visit. FAILURE TO HAVE A VALID REFERRAL AUTHORIZATION MAY RESULT IN YOUR APPOINTMENT BEING RESCHEDULED UNTIL A VALID REFERRAL IS RECEIVED. Our front office will assist you in pre-authorization of your services if needed. If you request to be seen without a valid referral, you will be responsible for payment of services rendered and will need to complete additional paperwork that allows us to bill you for those services. If your health plan requires pre-authorization, please notify your provider of this provision. PRE-AUTHORIZATION DOES NOT GUARANTEE PAYMENT. Failure to have your services pre-authorized if required by your health plan may result in denial of medical payment for services rendered. If payment is denied at any point prior to or after services, you will be responsible for payment of the balance in full. If you have any questions about your benefits or what services are covered under your health plan, it is your responsibility to contact your health plan prior to your surgery.

Co-Payments and Non-Covered Services

If your health plan requires a co-payment, we are required to collect it at the time of your visit. We cannot waive co-payments, deductibles, or co-insurance amounts, which are the patient's responsibility. If you cannot make the required payment, your appointment may be rescheduled. If you do not have health insurance coverage or request a service that is not covered by your health plan, we require payment in full at the time that service is rendered.

Patient Initials:_____

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Patient Responsibility for Billed Amounts

We will send you a statement of any remaining balance on your account after any health plan payments are applied. Payment is due in full within 30 days from the date that appears on your billing statement. If you cannot make payment in full, you will need to contact our office administrator to arrange a payment plan. If we do not receive payment from you within 60 days from the date of the first billing notice, we will attempt to contact you for payment. If we receive no further response within the next 30 days, your account may be turned over to our collection agency. IF YOUR ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, YOU WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS AND LEGAL FEES INCURRED.

Missing, Inaccurate, or Incomplete Billing Information

You are responsible for notifying our office of any changes to your health plan or billing information before you are seen at our office. Failure to notify us of changes may result in your being responsible for any remaining balance on your account. Our practice will not be responsible for any billing errors, lack of coverage or payment due as a result of missing, inaccurate, or incomplete information that you provided us, including information on secondary or third-party payment coverage.

If you have any questions about the above, please address them with the front office or the office administrator prior to signing this agreement. By signing below, I certify that I have read and understand the above and fully agree to the terms.

_X_____ _X_____

Patient Signature / Printed Name Date / Time