

Bayview Dermatology and Cosmetic Surgery, S.C.

FINANCIAL POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that Payment of your bill is part of this treatment and care. Please initial each of the following numbered items.

1. _____ if we participate with your managed care plan or you have a commercial insurance plan under which you are Covered, we will bill the carrier for all charges for services rendered. We will bill both primary and secondary insurance plan. You will be responsible at the time of service for the payment of: annual deductibles, Co-payments, Changes for non-covered Or cosmetic services.

In the event that we are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial From your insurance carrier. Please advised that anything you choose to have removed or biopsied may not be covered under your Office co-pay and is subject to your deductible. We will make every effort to contact your insurance to verify your benefits, but in The event we are unable to reach them, you will be responsible for your co-payment as well payment for any procedures performed. Such procedures include but are not limited to: biopsies, removal of warts, moles, pre-cancers, or other skin lesions. Methods of removal may include but are not limited to: cutting, freezing, burning, or application of blistering agent.

2. _____ we are Medicare participating provider therefore we will bill Medicare directly. You will be responsible for deductibles or co-payments or charges for non- covered or cosmetic services. You will be asked to sign a Waiver of liability Form in the event that a service is provided, which we know is not covered by Medicare.

3. _____ if you have no health insurance, payment is expected in full at the time of service.

4. _____ In the event we receive a returned check due to insufficient funds, a fee of \$ 25.00 will be charged to your account and payment is due upon receipt of your statement.

5. _____ if you purchase skin-care products or supplies from our office, please understand that these products/supplies are non-refundable item. In the event the product/supply is defective, we will gladly replace the item (s).

6. _____ we kindly request that you give us 24 hours notice if you are unable to keep appointment. Failure to give 24-hours notice will result in a \$35.00 missed appointment fee. This fee s not covered by your insurance plan.

7. _____ Co-payment is due at the time of visit, if you don't have the copay you will be charged an extra \$5.00 for processing fees or we will reschedule your appointment to another day.

If you have any questions, please do not hesitate to ask us. We are here to assist you any way possible.
Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Before you make a decision about your option you should read this entire notice carefully.

- . Ask us to explain, if you don't understand why you insurance may not pay for these services.
- . Ask us how much these items or service will cost you (Estimated cost: \$ _____), in case you have to pay for them yourself Or through other insurance.

Option 1. _____ Yes I want to receive treatment or services.

I understand that my insurance will not decide whether to pay unless I receive services. Please submit my claim to my insurance.

Option 2. _____ No I have decided not to receive treatment or services.

I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your option that my insurance will not cover there items or services.

Patient/Guardian Signature

Date