**APPOINTMENT AND FINANCIAL POLICY**

Thank you for choosing us as your health care provider. We are committed to providing quality medical care. Please understand that payment of your bill is considered part of your care plan. We ask that you read and sign this Financial Policy prior to any treatment. You may be asked to sign this page again as it is updated. Please let us know if you have any questions.

- We will verify your insurance coverage at every visit. It is the patient's responsibility to supply all current insurance cards. In-person and telemedicine appointments are subject to insurance billing.
- We may ask for a copy of your driver's license or picture identification issued from DMV for identity verification.
- We accept cash, checks, Care Credit, Amex, Visa, and MasterCard. A $25 fee will be assessed for returned checks.
- If your insurance requires a referral from your Primary Care Provider (PCP) to see another physician, it is your responsibility to obtain a referral/authorization prior to your appointment. Any unauthorized charges will be your responsibility.
- The adult accompanying a minor to a visit and the legal parents/guardians are responsible for full payment. We will not be involved in negotiating between parents in custody disputes.
- When labs, x-rays, or other tests are ordered by Frontier Derm Partners, you are responsible to check with your insurance company as to where you are authorized to have these studies done. We will not be responsible for any bill if you have a test done at the wrong location.
- Additional skin specimen pathology stains, tests, consultations may be required in-house by North Sound Dermatology, Silver Falls Dermatology, and/or at an outside laboratory institution. Additional pathology services will be billed separately and will not be included in bill estimates.
- If you are here for multiple procedures, the provider will determine whether or not to perform all these procedures during the same office visit or to schedule them at a future date. We cannot guarantee multiple procedures on the same day of service. Your insurance company may have one co-payment for the office visit and a second co-payment for the actual procedure. In addition, if we provide a non-covered service during the same visit as a medical dermatology encounter, then you will have two separate charges.
- All procedures (such as biopsies, liquid nitrogen/freezing, benign removals, skin tags, etc.) are billed separately and are not included in the office visit.
- Some procedures have a set number of days that are included in the surgical package, this is called a 'Global Period". Suture removals may fall under the global period, and no extra payment will be due. However, please note, if the provider discusses or performs anything besides the suture removal, the visit will no longer be considered global and will be billed to your insurance, and the appropriate patient balance will be due.
- No show appointments/cancellations less than 24 hours in advance may be charged a $50.00 for a standard appointment and $150.00 for a missed surgery appointment.
- Ambulatory Surgery Center patients may be charged a facility fee. This covers our expenses for maintaining an accredited ambulatory surgery center. Insurers consider procedures in an ambulatory surgical center out-patient surgery. Some insurance plans require increased coinsurance payment for these procedures - Medicare does not.

As a courtesy to our patients, we will submit claims to your insurance carrier for you. For those plans that we participate in, we will also submit secondary and/or tertiary claims. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered by your particular plan. Patients are responsible for knowing the details/rules of their health plan(s), as we cannot change our coding in an attempt to obtain payment.

****I have read, understood, and agree to the Financial Policy (above)****

**Patient Signature** ____________________________________________**Today's Date** ____________________________
*(Parent or legal guardian must sign if patient is under 18)*

**Patient Name** _______________________________________________ **Date of Birth** ___________________________

Effective 6/8/2021