



## OFFICE POLICIES

*\*\*This document is not open to revision & must be signed in its entirety\*\**

### I AGREE AND UNDERSTAND:

**Office visit charges are due at time-of service.** There will be a \$5 charge for office visit charges and previous balances not paid at the time-of-service. Co-pays, deductibles, and coinsurances are set by your insurance plan. If you are unsure about your insurance benefit coverage, please contact your insurance company. We are preferred providers for UnitedHealthcare, Aetna, Blue Cross, Premera, Lifewise, Asuris NW Health, First Choice Health, Uniform Medical, Coventry/First Health and Medicare. This office will courtesy bill\*\* all other insurance companies. Your insurance may not cover every procedure done in this office. It is your responsibility to contact your insurance for questions on coverage and benefit information. This includes Medicare. For patients who have Medicare, please ask the receptionist for the additional form.

*\*\*Patients with Columbia Community Care will need to sign a waiver or our office will be unable to courtesy bill their insurance.*

**PLEASE INITIAL \_\_\_\_\_**

This office reserves the right to add additional charges for the following:

- Returned checks: \$29.
- \$40 charge for appointments missed or canceled without 24 hours notice.
- If you are more than 10 minutes late for your appointment, it may be necessary to reschedule it. If it's necessary to reschedule, this will be considered a missed appointment.

Some cosmetic appointments require a deposit of \$100. This is nonrefundable if you fail to cancel your appointment with at least 24 hours notice.

**PLEASE INITIAL \_\_\_\_\_**

Each patient has an individual account at this office. We require patients to present their insurance card at each visit. If you are unable to provide us with a copy of your insurance card at the time of service you will be responsible for payment in full. You will also be responsible for submitting any claim to your insurance company.

**PLEASE INITIAL \_\_\_\_\_**

I authorize treatments and agree to pay all fees and charges for such treatments. I agree to pay all charges as shown by statements promptly unless credit arrangements are agreed upon. If you are unable to pay your balance in full, please contact our billing department to set up a payment plan. Balances not paid in full within 30 days will be considered in default and we reserve the right to transfer the account to our in-house collection department or a third party collection agency. I agree to pay all collection costs and any third party costs attempting to collect the debt. I also understand that unpaid debts may be reported to credit report agencies and may affect my credit score.

**PLEASE INITIAL \_\_\_\_\_**

**Please see the following page for additional information.**



Effective immediately our office will be charging \$25 to complete any third party forms and writing letters for compensation benefits. This fee is the responsibility of the patient.

**PLEASE INITIAL** \_\_\_\_\_

This office processes biopsy specimens in-house in a certified histology lab. The slides are then read and diagnosed by Dr. Robert Hopp who is board certified dermatopathologist. Occasionally a second opinion is necessary for diagnosis and these specimens are sent to a third party for review. There may be a separate charge accrued by the third party that will be billed to the patient or the patient's insurance. It is the responsibility of the patient to make sure the third party has their correct billing information.

**PLEASE INITIAL** \_\_\_\_\_

If you would like us to leave messages at your home regarding your office visits, health care, prescriptions, your account or anything else happening in the office.

**PLEASE INITIAL** \_\_\_\_\_

Minors are required to have a parent or legal guardian accompany them on all office visits.

**PLEASE INITIAL** \_\_\_\_\_

I am aware of the following potential complications as outlined for any procedure performed here at The Center for Excellence in Dermatology:

- Bleeding
- Infection
- Scar
- Nerve damage
- Postoperative problems
- Pain

**PLEASE INITIAL** \_\_\_\_\_

In the case of divorce or separation, the party/parties responsible for the account prior to divorce or separation remain responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**PLEASE INITIAL** \_\_\_\_\_

**NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU READ AND AGREE TO THE CONDITIONS SET FORTH. WE RESERVE THE RIGHT TO CHANGE THESE POLICIES AT ANY TIME. YOU ARE ENTITLED TO A COPY OF THE AGREEMENT AND MAY REQUEST ONE FROM THE RECEPTIONIST. KEEP IT TO PROTECT YOUR LEGAL RIGHTS.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

*(If patient is a minor, parent or guardian signature is required.)*

**PRINT PATIENT NAME:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT** *(if signed on behalf of patient):* \_\_\_\_\_