FINANCIAL POLICY AGREEMENT

Welcome to Alexandria Associates in Dermatology! We are pleased that you have chosen us as your provider for your dermatologic care. Our mission is to provide you with the highest level of professional medical care and patient satisfaction. To avoid any misunderstandings and to ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your healthcare. We require that all patients sign our Patient Authorization and Consent for Treatment form, as well as this Financial Policy Agreement before receiving medical services. The Financial Policy Agreement form confirms that you understand that the services provided are necessary and appropriate, and advises you of your financial responsibility with respect to services received.

PATIENT RESPONSIBILITY (initial here: ____)

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit, as well as any prior balance. Some insurance plans tell us exactly what you will owe at the time of your visit; in that case, we may request full payment for your share when you check in or out. Other insurance plans do not provide immediate information regarding your patient responsibility; in that case, you will be asked to save a credit card on file to settle your account when you check out.

If you save a credit card on file, we will charge your card for the balance due when your account reaches pre-collections status. If your card is declined, your account will be outsourced to a collections agency.

INSURANCE (initial here: ____)

We ask all patients to provide their insurance card and proof of identification (such as a photo ID or driver‘s license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e. self-pay). We accept assignment of benefits for many third-party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient's responsibility. Our fees are for physician services and procedures only; you may receive additional bills from laboratory, radiology, or other diagnostic related providers.

You are responsible to:

- Know if a referral or authorization is necessary for office visits (if it is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient)
- Check with your insurance plan to determine if prescribed testing (lab, radiology, etc.) is covered under your insurance policy. (If you choose to have non-covered testing, we will require full payment at the time of your visit)
- Check with your insurance plan to review the schedule of benefits and whether a co-payment or deductible applies.
- File any appeals with your insurance plan, if needed.

- Coordinate benefits if you have more than one insurance plan. You may be required to contact your insurance company to clarify which plan is primary or to correct any demographic or other issues.
- Arrive for appointments with all required documentation.

INSURANCE VERIFICATION (initial here: ____)

We will attempt to verify insurance eligibility (2) business days prior to your visit. If we are unable to confirm active insurance, we will contact you about your insurance eligibility. If you are unable to present an alternative form of active insurance coverage prior to the visit, you will be required to either pay at the time of your visit or reschedule your appointment. For same-day appointments, we will check eligibility when the appointment is made.

TYPES OF PAYMENT (initial here: ____)

1. **Co-payments.** Insurance carriers require that we collect your copayment at the time of your visit. If you are not prepared to make your copayment, you may reschedule your appointment.

2. **Deductibles.** Most insurance plans require a predetermined amount (the "deductible") before insurance will cover certain charges. We will bill you for the balance due for the services provided that are not met by your deductible.

3. **Co-insurance.** Some insurance plans require that you pay a certain percentage (for example, 20%) of the allowable charge amount. We will ask that you pay your co-insurance at the time of your visit.

4. **Uninsured patients / Self-pay.** If you do not have insurance or if the services provided are not covered by your insurance, payment for all services is due at the time of your visit.

5. **Out-of-network.** We participate with most insurance plans. You can contact your insurance company to confirm if your provider is in network prior to making your appointment. If we do not participate with your insurance plan and you choose to be seen in our practice as "out-of-network", you will be responsible for the payments your insurance does not cover.

6. **Non-covered services / Cosmetic procedures (i.e. procedures that are not medically necessary) / Products:** It is your responsibility to contact your insurance plan to determine whether a particular service is covered. If we provide you non-covered services, cosmetic services, or products, you are expected to pay for those in full at the time of your visit.

OUTSTANDING BALANCES (initial here: ____)

After your visit, we will send you a statement for any outstanding balances. All outstanding balances are due upon receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. Your outstanding balance can be paid conveniently by credit card through our website, by cash or check or credit card in our office.

We generally send statements once monthly, beginning when the balance becomes patient responsibility. If you have an outstanding balance for more than (90) days, you will be referred to an outside collection agency and charged a collection fee of 35% of the balance owed in addition to the balance owed. Also, if you have unpaid delinquent account, we may discharge you as a patient and you may not be allowed to schedule any additional services unless special arrangements have been made.

LATE ARRIVALS, CANCELLATIONS, AND NO-SHOWS (initial here: ____)

Late arrivals. If you arrive late for a scheduled appointment, you may be asked to reschedule your appointment or wait for an open appointment time on that day's schedule.

Cancellations. If you are unable to keep a scheduled *medical* appointment, you must call at least one (1) business day in advance or we may consider you a "no-show". If you are unable to keep a scheduled *cosmetic* appointment, you must call at least two (2) business day in advance or we may consider you a "no-show".

No shows. If you miss your appointment, you will be charged a $50 fee for a missed medical appointment, a $100 fee for a missed cosmetic or surgical appointment. This fee will need to be paid prior to rescheduling. This fee cannot be applied to insurance. As permitted by state law, you may be discharged as a patient following three (3) no shows in one year period (365 days).

CARD ON FILE PROCESS (initial here: ____)

When you check into a hotel and rent a car, you are required to provide a credit card to cover the cost of any incidental charges and/or pay your bill. This process benefits both you and the hotel or rental company by making the check out process easier, faster, and more efficient.

We have implemented a similar process at our practice. You will be requested to provide a credit card when you check-in for your visit and we will scan the card into our system. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. At that time, we will notify you of the remaining balance owed by issuing you a statement. We will charge your card for the balance due when your account reaches pre-collections status. An account reaches pre-collections status when there is non-payment following issuance of the third (3rd) statement and before submitting your account to an outside collections agency. You may call our office if you have a question about your balance. We will send you a receipt for the charge.

The "card on file" program simplifies our payment for you and eases the administrative burden on both you and the practice. Our billing team is available to answer any questions about the balance due. If you have any questions about the card on file payment method, please let us know.

Patient/Guarantor signature:_____ **Date:**_____