North Georgia Dermatology

Financial Policy
Effective August 1, 2012

North Georgia Dermatology is committed to providing you with quality care. As a patient of North Georgia Dermatology, you are financially responsible for all medical services. Your clear understanding of our financial policy is important to our professional relationship. Our office will be pleased to discuss our professional fees with you at any time.

Verification of Patient /Insurance Information
As a patient you are responsible for providing accurate and complete insurance information. At the time of scheduling your appointment, you will be asked to provide your insurance information. If we are providers with your insurance carrier, as a courtesy to you, we will file a claim with your insurance carrier. This is not a guarantee of payment.

Your health insurance is a contract between you and your insurance company. We are not a party to your contract. Therefore, North Georgia Dermatology cannot become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply factual information as necessary. You are responsible for timely payment of your account.

At check-in you will be asked to provide your insurance identification card, social security number, and state-issued identification. This is for your protection as well as to ensure that no changes in coverage have occurred.

Referrals
If you have a health plan that requires a referral from your primary care physician it is your responsibility to obtain this information prior to your appointment. It is also your responsibility to verify that you do not exceed the number of authorized visits by your primary care physician/health care plan. If you exceed your authorized visits you will be billed for all services rendered. <u>If you are unable to obtain a referral, your appointment will be rescheduled or you will be expected to pay for charges in full at the time of service.</u>

Co-Payments/Deductibles/Co-Insurance
Co-payments, applicable deductibles and co-insurance amounts will be collected at the time of your visit. If you are unable to pay when you are here, a $20.00 billing fee will be charged to you. In compliance with our contract with your insurance carrier North Georgia Dermatology cannot discount/waive any co-payment, deductible and/or co-insurance amounts.

Cancellation/No Show Policy
Our office asks that you please cancel any unwanted or unneeded appointment at least 24 hours in advance for an office visit appointment and 48 hours in advance for a surgery or cosmetic appointment. Please be advised that we have implemented a new policy, which states; if a patient has two "no shows" for any scheduled appointment within a calendar year, they will be assessed a "no show" fee for the second and any subsequent missed appointment. Our no show fees are $50.00 for a missed office visit appointment and $100.00 for a missed surgery or cosmetic procedure appointment. Any "no show" fee would need to be paid prior to scheduling an appointment or refilling a prescription. Reminder calls and emails are made as a courtesy, should you <u>not</u> receive a reminder call and you miss your appointment, you will be charged a "no show" fee.

Cosmetic Procedure Policy
Upon scheduling a cosmetic procedure, it is our policy to either collect the balance of the expected procedure or secure a credit card number (which will not be charged until the procedure has been preformed.) In the event you cancel with less than a 48 hour notice or you "No Show" for the appointment, one half of the procedure will be withheld or charged to your credit card.

OVER →

Self-Pay/Non-Contracted plans/Non-Covered Services/Third Party Claims
Payment in full will be collected at the time of your office visit.

Medicare Patients
If you have regular Medicare part B and a secondary carrier (Medi-Gap Plan) we will not collect any payment at the time of your visit. Our office will bill you for any portion of your bill not paid by Medicare and your secondary carrier.

If you have regular Medicare part B only and have not met your deductible, we will collect the deductible amount along with your 20% co-insurance at the time of your visit.

If you have regular Medicare part B only and have met your deductible, we will only collect your 20% co-insurance at the time of your visit.

Out of Network Patients
Any applicable deductible, co-payment, co-insurance, and non-covered services will be collected at the time of your visit. Please contact your insurance carrier for guidelines pertaining to your coverage.

Medical/Billing Records Requests/patient Document Requests
All records requests must be submitted in writing and must include a signed release from the patient. The fee for each of these requests is $25.00, which is required prior to any records being released. All records requests will be processed within 5 working days from the receipt of payment.

Patient Balances
Any patient balance due after your insurance company has processed your medical charges will be billed and is due upon receipt. If the balance is not paid or payment arrangement established, your account will be forwarded to an outside collection agency within 90 days of the first billing statement. You will be responsible for any collection costs, attorney fees, filing fees and court costs if any past due balance is placed with an agency for collection or with any lawsuit or legal action.

Upon arrival for any appointment, any outstanding balances due will be collected at check-in.

Checks
If paying by check, you authorize us to use information from your check to process a one-time Electronic Funds Transfer (EFT) from your account and you will not receive your check back from your financial institution. In the event of a returned check, a $37.00 fee will be added to your balance. We do not accept third-party checks. We do not "hold" checks.

Methods of Payment
Our office accepts cash, electronic check (with proper identification), Visa, MasterCard, and Discover.

- I have received a copy of North Georgia Dermatology's Financial Policy, which I have read and understand.
- I understand that I am personally responsible for payment on my account.
- In the event my insurance company deems a service to be "non-covered", I understand that I am personally responsible for payment.

Patient Printed Name & Date of Birth_____

Patient (Guarantor) Signature_____Date_____