DFW Skin Surgery Center PLLC

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FINANCIAL POLICY STATEMENT

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we offer the following information regarding our insurance and financial policies.

Your insurance is a contract between your insurer and you. It is your responsibility to know and understand the terms, guidelines and limitations of your plan. It is also your responsibility to advise us of any changes in your insurance, your address or your employer.

Medicare & Contracted Insurance Plans
If you are on traditional Medicare or are a member of a health plan that we participate with, we will submit your claim to your insurance company. Our staff will verify your benefits and collect any co-payment, co-insurance, and deductible at the time of service, as required by your insurance carrier. You will be billed in full for any services that your health plan considers a non-covered service.

Secondary/Supplemental Insurance Plans
We will file secondary and supplemental claims as a courtesy. In the case of non-contracted secondary carriers, the balance will become patient responsibility 30 days after that claim is filed.

Non-Contracted Commercial Insurance Plans
If we do not participate in your insurance plan, payment in full will be required at the time of service. You will receive an itemized statement, which you may then file with your insurance carrier. Please be aware that your out-of-pocket expenses may be higher when seeing an out-of-network provider.

Medicaid
We are not contracted with any Medicaid plan. Medicaid patients seeking services are responsible for payment in full at the time of service.

Minors
A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. If this is a custodial parent, we can submit the charges to another parent's insurance, however, the parent presenting the child for care will be billed for the balance not covered by the insurance. Any patient over the age of 18 will be held financially responsible for all charges incurred.

Missed Appointments
Missed appointments represent a cost to us and to other patients who could have been seen in the time allotted. Cancellations must be made 24 hours in advance of the scheduled appointment or we reserve the right to assess a fee.

Medical Records
Copies of pathology reports are provided to you or another physician at no charge. Any additional medical records requests and/or completion of forms (e.g. disability, life insurance, cancer policies, etc.) are subject to processing fees determined by state law and contractual agreements. Please be advised that medical records requests require time to be processed and cannot be provided the same day requested.

Collection Fees
Statements are sent out monthly for patients with account balances. Payment is due upon receipt of the statement. If you are unable to pay the balance in full, please contact our billing department. Account balances over 90 days from the date of service will be sent to a collection agency. In the event an account is turned over to an outside collection agency, patients will be responsible for any collection fees, including court costs, attorney fees, and collection agency charges.

Returned Check Fee
A $25 fee will be added to your account balance in addition to the amount of the check returned for insufficient funds. This total must be paid by cash or credit card within 14 days.

Pathology Fees
When a biopsy is performed, DFW Skin Surgery Center, PLLC, sends the specimen to an outside laboratory for processing and interpretation. The laboratory will typically bill your insurance; however, you may receive a bill from the outside lab for any outstanding balance.

Cosmetic Services
Patients are financially responsible for all cosmetic procedures at the time of service. This office does not bill insurance companies for cosmetic procedures. All applicable cosmetic fees will be discussed prior to the initiation of treatment.

My signature below indicates that I have read, understand and will comply with the information contained within this financial policy. A copy of this policy is available upon request.

Patient or Guardian Signature: _____ Date: _____/_____/_____

Relationship (if other than patient): _____