DFW Skin Surgery Center PLLC

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Arlington, TX 76012

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Southlake, TX 76092

: (817) 303-MOHS (6647)
: (817) 303-6651
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FINANCIAL POLICY STATEMENT

We want our financial and insurance policies to be clear and understandable. Please review the information below regarding your financial responsibility for services provided by DFW Skin Surgery Center.

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 and to advise us of any changes in your insurance, address, or employer.

Medicare & Contracted Insurance Plans
If you have traditional Medicare or a health plan with which we participate, we will submit your claim to your insurance company. We may verify available insurance benefits as a courtesy; however, verification of benefits is not a guarantee of coverage or payment. You are responsible for applicable copayments, coinsurance, deductibles, and non-covered services as determined by your health plan.

Secondary/Supplemental Insurance Plans
We will file secondary and supplemental insurance claims as a courtesy. If a non-contracted secondary carrier has not paid within 30 days after filing, the remaining balance may become the patient's responsibility, subject to applicable insurance requirements.

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
DFW Skin Surgery Center does not participate in Medicaid. Please notify us if you have Medicaid coverage so that we can determine whether we are able to provide the requested service on a self-pay basis.

Self-Pay Patients
Patients who are uninsured or who choose not to use insurance may request a Good Faith Estimate of expected charges. When required by federal law, a Good Faith Estimate will be provided before scheduled services.

Minors
A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. If a custodial parent presents the child for care, we may submit charges to another parent's insurance; however, the parent presenting the child will be responsible for any balance not covered by insurance. Patients age 18 and older are financially responsible for 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 should be made at least 24 hours in advance of the scheduled appointment. We reserve the right to assess a fee for late cancellations or missed appointments.

Medical Records
Copies of pathology reports are provided at no charge. Requests for additional medical records or completion of forms may be subject to fees as permitted by applicable law. Please allow adequate processing time for record and form requests.

Collection of Past-Due Accounts
Payment is due upon receipt of your statement. If you are unable to pay your balance in full, please contact our billing department. Past-due accounts may be referred to an outside collection agency. Patients may be responsible for reasonable collection costs, court costs, and attorney's fees to the extent permitted by law.

Returned Check Fee
A $30 fee will be added to your account balance for a check returned for insufficient funds. The returned amount and fee 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 laboratory for any outstanding balance.

Cosmetic Services
Cosmetic services are not submitted to insurance and are payable in full at the time of service. All applicable cosmetic fees will be discussed prior to treatment.

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

Patient or Guardian Signature: _____ Date: _____

Relationship (if other than patient): _____