OUR FINANCIAL POLICY

Thank you for choosing Columbus Skin Surgery Center and Dr. Sharon Thornton as your dermatologic healthcare provider. We are committed to your successful treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Insurance

All patients must complete our patient information and insurance form before being seen by the doctor. We accept assignment from many insurance companies, but in the event that your insurance does not cover your treatment within a reasonable time the balance will be transferred to the patient's or guarantor's responsibility. Please be aware that some of the services you receive may be non-covered services or considered not medically necessary under Medicare and/or other medical insurance. We make every attempt to notify you when a service may not be covered; however, due to numerous rules with different insurance companies it is not possible for us to always know when the insurance company may make a determination to disallow payment for a service.

I understand that Columbus Skin Surgery Center will make every attempt to notify me when services may not be covered by my insurance. Upon determination by my insurance, I will be responsible for any services that are not covered:

Initials: _____

We must emphasize that our relationship is with you, not your insurance company. While we make every attempt to provide the insurance company with the information necessary to process the claim, it is your responsibility to provide information your insurance company requests from you in order to coordinate your benefits, verify you were eligible for coverage at the time of service, and to dispute claims your insurance company denies. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are ultimately your responsibility. **You must notify us of any insurance changes in advance of your visit so we can ensure that we are in-network and that the bill is forwarded to the correct insurance company.**

I understand that I am responsible to provide accurate insurance information to Columbus Skin Surgery Center. I also understand that if I am ineligible for benefits at the time services are rendered I will become responsible for the amount due.

Initials: _____

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what those rates should be.

All co-pays and deductible amounts owed are due at time of service. If your insurance applies any portion of your charge to your annual deductible or coinsurance, that portion is due and payable by the patient. If you have elected to use our practice and we are out of your network of coverage, please check with your insurance regarding coverage. Your employer or provider of insurance determines your benefit coverage by contracting with a particular insurance company. If you have questions regarding your coverage, please speak with your human resource person or use the web address listed on your card. **It is the patient's responsibility to understand coverage.**

I understand that I am responsible for payment for all out of network services. I also understand that Columbus Skin Surgery Center may charge a $20.00 billing service fee for any co payment due that is not paid at the time of service.

Initials: _____

<u>High Deductible Health Plans (HSA, HRA, MSA participants) and 80/20 Health Plans</u>

If you are a participant in a High Deductible Health Plan (HDHP), a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA) or a Medical Savings Account (MSA) please notify us prior to your visit. You must be prepared with the plan information and pay the patient responsible portion from the HSA, HRA or MSA **at the time of service**.

If we are not able to determine the amount you owe for the services provided or the amount of patient responsibility remaining on your high deductible plan we require a deposit $35.00 for office visits, $150.00 for Excisions and $500.00 for Mohs micrographic surgery to be applied to the balance owed under your deductible. The charges for the visit that day will be billed to your insurance and we will balance bill you any amount remaining over your deposit that is applied to your deductible once the insurance company processes your claim. If desired, our billing coordinator will be glad to provide you with an estimate of the total expected charges and the deposit amount prior to services being rendered.

If you are a participant in an 80/20 Health Plan we will require a deposit for Mohs micrographic surgery. You must be prepared with the plan information and pay the deposit in the amount of $100.00 at the time the service is rendered. If desired, our billing coordinator will be glad to provide you with an estimate of the total expected charges

I understand that Columbus Skin Surgery Center will bill my insurance and any amount remaining that is applied to my deductible and or coinsurance will become payable upon the first statement I receive. My deposit outlined in the above 3 paragraphs will be applied to the deductible/coinsurance amount and I will receive a balance bill for any charges still owed:

Initials: _____

Patient Responsibility / Uninsured

Please request a meeting with our billing coordinator to discuss payment if you are seeking a service that is predetermined to be non-covered, such as cosmetic procedures, or if you do not have insurance or if you are a participant in any insurance for which we are not a provider. In these circumstances we require that you be prepared to pay our fees at the time services are rendered.

If you have a work related illness or injury, please notify our receptionists upon arrival to ensure the proper paperwork is completed before your visit.

Missed Appointments

We ask that if you are unable to keep an appointment, that you call us as early as possible to reschedule. In order to provide the best possible service and availability to all our patients, it is our policy that if you miss an appointment without cancellation prior to the day of the appointment, you may be charged a $50.00 fee. If you miss two or more appointments, we may refuse to continue providing care to you.

I understand that I will be responsible for a $50.00 no show fee if I do not cancel my appointment within 24 hours of the scheduled date and time. I also understand that my insurance will not cover this no show fee and I will be responsible for the charge.

Initials: _____

Pathology and Other outside Services

You may receive a separate bill for services performed outside our office, such as pathology, cultures, labs, etc. Questions regarding those charges should be directed to the appropriate external service provider.

Payment Details

We accept cash, check, Visa, Mastercard and Discover. We reserve the right to process your payment electronically based on information you provide to us. Any returned checks are subject to a $35.00 collection fee. Returned checks must be resolved before any future appointments can be scheduled.

Minor Aged Patients

Parents or guardians are responsible for payment of any fees not covered by insurance for that minor. For unaccompanied minors, treatment will be denied unless we have received the proper paperwork.

Account Delinquency and Credit Reporting

In the event your account with us would be referred to collections, your credit history may be obtained. Any balances not paid within Columbus Skin Surgery Center's policy that are referred for collections may negatively affect your credit history. An account is considered delinquent and may be referred for collections when the patient has not responded to statements or when one or more payments have not

been made. If you are unable to adhere to a payment agreement you must contact us to discuss alternative arrangements.

We also reserve the right to bill a collections fee equal to 30% of the amount owed in addition to the outstanding amounts owed for services rendered. All outstanding balances must be completely paid in order for future visits to be scheduled. If not resolved in a timely manner, we reserve the right to dismiss you from our practice.

I have read this Financial Policy. I understand and agree to this Financial Policy.

_____

Patient's Printed Name

_____ _____

Signature of Patient or Responsible Party Date