

New Age Dermatology Financial Policy

We would like to share the following policies with you so that you may understand your responsibility regarding the charges for services rendered to you by this office. We welcome any questions you may have regarding this information.

Contracted Insurance Plans:

If we participate with the insurance plan under which you are covered, we will bill your insurance company for all charges for services rendered. If you are covered by a secondary plan, and it is an insurance that we participate with, we will also bill the secondary insurance company for all charges for services rendered. If you have a secondary insurance that we **do not** participate with, it will be your sole responsibility to file to your secondary insurance company. You will also be responsible for any balance remaining after your primary and/or secondary insurance plan has paid, and we have taken the contracted adjustment.

The insurance companies that we currently participate with are as follows: Blue Cross Blue Shield, Wellpath, Cigna, Aetna, United Health Care, Medicare, North Carolina HealthChoice for Kids, and Secure Horizons. We do not participate with fee-for-service plans. If you have any other insurance, please ask us if we currently participate as the list may change without notice.

We expect payment up front for any / all of the following as they apply to each individual:

I. Deductible

II. Co-payment

III. Charges for all non-covered services or cosmetic services

If your insurance plan requires a referral from a primary care doctor, it is **your responsibility** to obtain and provide to us that referral preceding your scheduled appointment with us. If you have not done so at the time of your visit you will be required to sign a payment waiver before being seen by the physician. This payment waiver states that you will be responsible for all charges for services rendered if not paid by your insurance company.

Although we put forth every effort to notify our patients of charges that are commonly denied as non-covered services, it is impossible for us to determine what each individual plan may or may not cover. You will be responsible for payment of any charges deemed not covered by your plan.

Non-Contracted Insurance Plans:

Payment is expected up front for all office visits and procedures if you are covered under an insurance that we currently do not participate with. We accept cash, checks, Visa, Mastercard, Discover, and American Express as payment. In the event that a personal check is returned to us uncollected from your bank, your account will be assessed a \$25.00 returned check fee.

Billing Process once a Claim has been Filed:

If we do not receive a response from the insurance carrier within 30 days of filing, we will submit a second claim.

If we do not receive a response from the insurance carrier after 60-90 days, you will receive a statement, and you should then contact your insurance company regarding payment.

Any balance remaining after 90 days will be the patient's responsibility.

After 120 days from the original date a claim has been filed, we reserve the right to place accounts with an outside collection agency.

Payment Plans:

If you are having financial difficulties, we ask that you discuss payment arrangements with our Reimbursements Manager. If you are offered an extended payment plan, and you miss a scheduled payment, any or all prior arrangements become null and void. (Please note that a payment plan will only be offered for cases requiring a surgical procedure that involves removing a skin cancer or in emergency situations that immediately affect the well being of the patient).

Consent for Treatment:

I, the undersigned, voluntarily consent to medical treatment under the professional judgment of the on site physician and her staff. I understand that the medical treatment performed is necessary or beneficial to my condition. I acknowledge that no guarantees have been made to me as to the effects of such examination or treatment.

By signing this form below, you are stating that you understand our financial policy, and your responsibility regarding charges incurred in this office.

→ _____
Patient's signature

_____/_____/_____
Date