

## **DERMATOLOGY SURGERY CENTER PRACTICE POLICIES**

### **ASSIGNMENT OF INSURANCE BENEFITS**

The undersigned hereby authorizes the release of any information in relation to all claims, including Medicare for benefits submitted on my behalf and/or my dependents. I further agree and acknowledge that my signature of this document authorizes my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each claim form to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed each claim. I hereby authorize my insurance carrier to pay and assign all medical and/or surgery benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Scott L. Beals, D.O. I authorize the release of any medical records for treatment, payment or healthcare operations.

**INSURANCE COVERAGE IS NOT A GUARANTEE OF PAYMENT FOR ANY CLAIM, FURTHER I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED REGARDLESS OF INSURANCE COVERAGE. COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.**

### **RELEASE OF PATIENT INFORMATION**

I acknowledge that records concerning the patient are the property of Dermatology Surgery Center and are maintained for the use and benefit of Dermatology Surgery Center and its staff in providing care and treatment to the patient. I hereby authorize Dermatology Surgery Center to disclose all or any part of my patient records to my admitting physician, consulting physician(s), hospital based physicians. I further authorize Dermatology Surgery Center and providing physicians to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to Dermatology Surgery Center or to me or a family member of mine, for all part of Dermatology Surgery Center's charges, including but not limited to, hospital or medical service companies, insurance companies, Worker's Compensation carriers, welfare agencies, or my employer, provided such release of information shall be in accordance with state and federal laws and regulations.

### **FINANCIAL AGREEMENT**

For and in consideration of services rendered, each of the undersigned agrees to pay Dermatology Surgery Center for all charges not covered by insurance and any insurance administrative/ payment processing fees incurred by Dermatology Surgery Center as statements are rendered. Further, should it become necessary to enforce collection of any unpaid balance for medical services rendered, each of the undersigned agrees to pay all collection and legal expenses incurred by Dermatology Surgery Center including reasonable attorney's fees which shall include but not be limited to such fees incurred prior to institution of litigation, or in litigation, including trial and appellate reviews, and in arbitration, bankruptcy, or other administrative or judicial proceedings. Pursuant to Florida Statutes 222.111, the undersigned patient and/or responsible party waives his or her exemption to have disposable earnings of the head of the family which are greater than \$500 per week garnished.

**PLEASE NOTE: PATIENTS WHO NO SHOW OR FAIL TO CANCEL THEIR SCHEDULED APPOINTMENT WITHIN 24 HOURS OF THEIR APPOINTMENT TIME WILL BE CHARGED A FEE OF \$50.00 FOR EVALUATIONS OR A FEE OF \$100 FOR SURGICAL PROCEDURES.**

- **Cosmetic procedures must be paid two days prior to the procedure to avoid a \$100.00 charge FOR NO-SHOW or FAIL TO CANCEL their scheduled appointments.**

### **ACKNOWLEDGEMENT OF HEALTH INFORMATION PRACTICES** (HIPAA Privacy Guidelines)

The Dermatology Surgery Center Notice of Health Information provides information about how health information about patients may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand the terms of this Notice may change and that a copy of the revised Notice will be posted. By signing this form, I acknowledge that I have been offered and/or received the Dermatology Surgery Center Notice of Health Information Practices.

### **COMMUNICATION**

I grant permission for Dermatology Surgery Center to communicate via phone, voicemail or email in regards to my health information, care, and appointments.

### **AUTHORIZATION FOR MEDICAL CARE AND TREATMENT**

1. I recognize that a condition exists requiring medical care and I voluntarily consent to such medical care and treatment, diagnostic procedures by Dermatology Surgery Center and its medical and professional staffs, associates and agents and as deemed necessary.
2. I hereby authorize my physician, as provided by law to furnish medical treatment, diagnostic procedures, x-ray diagnosis or therapy as he considers necessary and proper in the treatment of the patient.
3. I am aware that the practice of medicine and surgery, and the administration of medical care, are not exact sciences and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures, treatments, examinations or care undertaken with Dermatology Surgery Center.

The contents of this form have been fully explained to me and I have been given the opportunity to ask questions. Any questions which I have asked have been answered to my satisfaction. I certify that I understand the contents of this form.

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Print Name

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Signature

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Date

## PATIENT CARE POLICIES

### Medical Records

- ALL PATIENTS NOW HAVE FREE ACCESS TO THEIR RECORDS THROUGH OUR ONLINE PATIENT PORTAL. Ask the front desk if you have not received this information. Any records that you would like to have printed or faxed to another facility by our office will have an ADMINISTRATION FEE:
  - These fees are based on Florida law, Statutes 395.3025. Fees are:
    - \$1.00 per page for the first 25 pages
    - \$0.25 per page for each additional page.
- To comply with government regulated HIPPA Privacy Laws, we need you to SIGN A RECORDS RELEASE FORM. You can sign this form in the office or download it from our website. Please bring a signed copy by the office or send by fax or email.
- PLEASE ALLOW 2 WEEK FOR RECORDS TO BE PROCESSED. Medical providers review your records before we release them. Records will be reviewed on a first come first served basis outside of patient service hours.

### Prescription Refills

- You must come to the office for an examination and evaluation by a Dermatology Surgery Center provider annually to receive a prescription refill.
- Please have your pharmacy send a fax to our office for your medication refills. Please allow 3 to 5 business days for all refill requests to be processed. Refill requests will be handled after patient service hours.

### Call Back Policy

- Please allow 3 to 5 business days to receive a return phone call. If you would like to schedule a time to visit with the provider, please schedule an appointment so that we may address your concerns.

## FINANCIAL POLICIES

Complete understanding of and cooperation with our practice financial policy is an essential element of your care and treatment. For your convenience we accept cash, check and major credit cards. Please remember, whether you have insurance or not, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please do not hesitate to ask or call our office. Our friendly staff is ready to help and provide any information.

### No-Shows or Failure to Cancel

- We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel an appointment by you to avoid any cancellation fees.
- **PATIENTS WHO NO SHOW OR FAIL TO CANCEL THEIR SCHEDULED APPOINTMENT WITHIN 24 HOURS OF THEIR APPOINTMENT TIME WILL BE CHARGED A FEE OF \$50.00 FOR EVALUATIONS OR A FEE OF \$100 FOR SURGICAL PROCEDURES.**
- Cosmetic procedures must be paid two days prior to the procedure to avoid a \$100.00 charge FOR NO-SHOW or FAIL TO CANCEL their scheduled appointments.

### Insurance Policy

- Dermatology Surgery Center is a participating provider with most major insurance companies.
- Insurance coverage is verified prior to being seen at each appointment. It is your responsibility to provide us with the correct information to bill your insurance.
- Your insurance is a contract between you, your employer, and the insurance company. We are not a part of that contract. It is very important that you understand the provisions of your policy. We cannot guarantee your insurance company will pay all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder.
- If you are covered by one of our participating plans, your predetermined portion of charges set by your insurance plan (co-pay and/or co-insurance and deductible) will be collected at the time of service.
- If you are not covered by one of our participating plans, we will file your insurance claim for you as a courtesy. You will be expected to make payment in full at the time service is rendered.
- After we submit a claim for payment to your insurance company for services provided at your office visit, they will determine what charges they will and will not pay. Your company should send you an Explanation of Benefits form, explaining their payment and what you may still owe based on your policy agreement.
- Your insurance company will pay Dermatology Surgery Center their portion of your charges and notify us of any remaining balance that may be owed by you.
- Any balance owed by you will be charged to your account and you will receive a bill.
- If your insurance company denies our charges or does not pay us in a timely manner, we will charge that balance to your account.
- You may take advantage of our credit card policy and avoid having multiple bills mailed.
- If your account becomes delinquent, we reserve the right to refer your account to a collection agency and to be reported to the credit bureau.

**ACKNOWLEDGEMENT OF FINANCIAL AND PATIENT CARE POLICIES****SIGNATURE REQUIRED TO BE SEEN**

I understand that insurance coverage IS NOT A GUARANTEE of payment for any services claimed by myself or Dermatology Surgery Center. Further I understand that I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES incurred, regardless of insurance coverage or payment of copays or deductibles due and collected at time of service.

By signing below, I acknowledge that I have read the Dermatology Surgery Center Financial and Patient Care Policies. I certify that I understand these Policies and will comply with them.

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**Printed Name**

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**Signature**

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**Date**

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