

Office Communications

I authorize Mid-Atlantic Skin Surgery Institute to release the necessary information to complete and process insurance claims. I assign insurance benefits to be paid directly to the Practice for services I receive.

I hereby consent and state my preference to have my provider and other staff at Mid-Atlantic Skin Surgery Institute to communicate with me by email or standard SMS text messaging regarding various

aspects of my medical care, which may include, but shall not be limited to, appointments, prescriptions,

laboratory results, and insurance balance billing. I understand that email and standard SMS text

messaging are not confidential methods of communication and may not be secure. I further understand

that, because of this, there is risk that email and standard SMS text messaging regarding my medical

care may be intercepted and read by a third party.

# Business Financial Policies

*Thank you for choosing Mid-Atlantic Skin Surgery Institute. Our goal is to provide and maintain a good physician-patient relationship. Letting our patients know in advance of our practice financial policy allows for clear understanding of the outlined patients and practice financial responsibilities. This financial policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for services.*

1. Insurance. Our office will verify your insurance eligibility. Some insurance companies will require referrals, and pre-authorization. We will contact your insurance plan to obtain pre-authorizations and gladly assist you in meeting referral requirements when requested, however, the responsibility is yours to ensure that such requirements are complete prior to treatment. If it is required, and not completed, you may need to reschedule your appointment.

I understand it is my responsibility to contact my insurance company to determine whether this office is in network with my medical insurance coverage and to inform the office of any changes to my insurance.

2. Co-payments and deductibles. Determined by the insurance.

I understand that co-pays, prior balances, and deductibles are due at the time of service, as I agree that I am responsible for balances on my account that are not covered by my health insurance plan and determined as patient responsibility.

3. Noncovered services. **Determined by the insurance.**

I understand that some, and perhaps all, of the services may not be covered by my insurance or not considered reasonable or necessary.

4. Updates and coverage changes. Our staff will ask you for ID to verify your billing information every visit. If your personal information or insurance changes, please notify us as soon as possible so we can make the appropriate update to help you receive your maximum benefits.

I understand current information is essential for scheduling services and for obtaining timely payment from your insurance company.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly.

I understand it is my responsibility to comply in a timely manner with the requested information to process my insurance claim and avoid unpaid balance transfers to me as patient responsibility.

6. Self-Pay patients. Patients will be provided with an estimate (GFE) in accordance with the NSA.

I understand as a Self-Pay patient, the Practice will collect payment in full at the time of service.

7. Products, Packages + Prepayments. Cosmetic procedures are not covered by insurance.

I understand that product purchases are non-refundable. Package payments and pre-payments for cosmetic services are non-refundable. If I change my mind about receiving the services for which I pre-paid, I may use these funds towards other services and products, and at current pricing. ALL pre-payments expire after 1 year (12 months) from the last date of service performed.

8. Patient who are minors. Responsibility for minors under the age of 18 years.

CHILDREN UNDER 18 MUST HAVE A PARENT / GUARDIAN PRESENT: Children under the age of 18 cannot legally consent to their treatment. Treatment can only be approved by a parent or legal guardian. If you cannot attend their appointment and must send your child with someone other than a Parent or Guardian, please be aware that they have no legal authority to provide a “consent to treat” for your child. You must send a signed letter of authorization with them or give us written pre-authorization naming the person(s) you approve of in advance to consent to treatment on your behalf. If you wish to do this, please request a pre-authorization form from our front desk staff.

**9. Payment options.** We accept cash, under $100 checks, credit and debit cards. Financing option through Care Credit-a wellness and beauty credit card- is also available for patients that are cardholders or are interested in applying to be one. If approved, the funds could be available to you immediately after.

I understand the payment options and that my account will be charged $35 if my check is returned for non-sufficient funds (NSF).

10. Statement showing outstanding balances. Patients will receive an itemized statement with their outstanding balance. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

I understand balances determined by my insurance as patient responsibility must be remitted within 30 days of the statement date. Partial payments will not be accepted unless otherwise pre-arranged.

11. Appointment cancellations/Rescheduled/No-Shows. We ask that you please understand that our appointment times are scheduled to allow us to take care of each individual patient’s needs during their visit. Please arrive on time for your scheduled appointment. Arriving more than 10 minutes late may result in appointment cancellation.

Failure to cancel an appointment without a 48-hour notice or failure to show up (NO SHOW) for a scheduled appointment will result in a $25 cancellation fee. After 3 missed or cancelled appointments, patients may be subject to dismissal from the practice.

As a courtesy we provide confirmation emails, text messages and phone calls. Please be sure to verify we have the most up to date contact information.

**12.** **Prescription refills:** Please allow 3 business days for prescription refills. In the case of certain medications, we require a follow-up visit to ensure the patient is prescribed the appropriate medication, as many dermatology conditions change as do the medications.

**13.** **Prior authorizations for certain medications and procedures:** In some cases, insurance companies require prior authorizations for certain medications and or procedures. The process to obtain a prior authorization can take up to 1-2 weeks depending on the medication or the nature of the procedure(s). Not all prior authorizations are approved, and the patient will be prescribed an alternative medication if available.

**14. Kind and Friendly Environment. Everyone deserves respect.**

Please come to appointment without any offensive/overwhelming smells (tobacco, marijuana, body odor, etc.). Any patient exhibiting signs of intoxication, disorientation, or strong odor will need to be rescheduled. Vulgar language or other offensive disruptive behavior will be considered reasons for dismissal from the Practice.

Patient Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Responsible Party if a Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_