Hendersonville DERMATOLOGY

Office and Financial Policies

Thank you for choosing Hendersonville Dermatology, PLLC for your dermatology care. We are committed to providing you with the highest medical care, in an efficient, timely and cost-effective manner.

Please remember that you/your responsible party are fully responsible for the payment of all medical bills. A photocopy of your ID and insurance card is needed by our insurance department to assist you in filing your claim. We must have current information concerning your insurance carrier in order to file your claim successfully. If we do not have the correct information, payment of your claim will be delayed. If your insurance plan requires a referral or pre-authorization, it is your responsibility to ensure we have one on-file at the time of your visit.

Please understand that your medical insurance is a contract between you and your insurance company. Our office will do its best to ensure that your claim is paid, but if your insurance company has not paid your account in full within 90 days it may then become your responsibility to pay the balance. You are ultimately responsible for all fees relating to your care. Any amount not covered by the insured/patient's insurance is due within 30 days of the time of service. Cosmetic services are not covered by insurance, cannot be submitted to insurance and payment in full is due at the time of service.

Medicare Patients
We will bill Medicare for you. In order to do this, we must have your signature on file. We will also bill secondary insurance carriers for you. All copayments are due at the time service is provided.

Preauthorization/Card of File Policy
By signing our Financial Policy Acknowledgment you consent to us keeping a credit/debit/HSA card on file to be used for any unpaid balances. You also authorize Hendersonville Dermatology, PLLC to charge your card for any outstanding balances. Charges will only be made after the claim has been adjudicated by the insurance carrier. You will have received an explanation of benefits (EOB) from your insurance company discussing charges that were authorized to be billed by the insurance company. If your balance exceeds $500 you will receive a phone call or email prior to authorizing the card on file. In the rare event of an overcharge, or credit balance on the account, the money will be directly refunded to the card on file unless you ask for a manual check refund.

If you choose not to leave a credit card on file, you have the option to leave a $250.00 deposit with cash or check.

We accept cash, personal checks and Visa, MasterCard and Discover cards; we do not accept American Express. A $25 charge will be added for any non-sufficient funds notice from the bank.

Co-Payments, deductibles and fees Co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are due at time of visit. Failure to produce payment may result in your appointment being rescheduled.

Self-pay Patients Self-pay or uninsured patients are responsible for payment at the time of service. The fee schedule is based upon the established Medicare fee schedule in place.

Prior Account Balances At the time of appointment, patients are responsible for any prior balance that is owed to the office. Account balances must be current before any new procedure or treatment will be performed. You may be rescheduled until the balance is paid in-full. Failure to pay bills may result in dismissal from our practice.

No Shows and Late Cancellations
We require advance notice of 24 hours if you must cancel/reschedule your appointment. If appropriate notice or explanation is not given you will be charged $75, which will be paid by your card on file or deposit. This applies to new patients, and/or existing patients with a history of missing appointments.

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Minor Patients
A parent or guardian must accompany a minor for their first visit or provide the office with a written consent for treatment before the appointment time. A parent or guardian is responsible for providing current insurance information for the minor as well as the payment in full for services provided.

Payment Agreements
We understand that life can present unforeseen financial challenges. If you are experiencing financial hardship ask to speak with Therrissa Cohen our Office Administrator, to discuss payment options. A payment agreement stays in effect until the balance is paid in full. When an agreement is made it will spell out the length of the agreement and the patient signs that agreement with the understanding of the length of the agreement. Payments will be applied to a credit/debit/HSA card on file until the balance is paid in full. In all circumstances, however, the responsible party on file will be held accountable for all patient balances.

Pathology and Laboratory Services
Hendersonville Dermatology, PLLC uses third parties for ur laboratory work and pathology services. If a blood draw or biopsy-excision is performed, be advised that you/your insurance will receive an additional bill. While our pathology and lab service providers generally participate in the same insurance plans as us, it is ultimately your responsibility to pay for all pathology/laboratory charges. If you have questions regarding these bills, please contact the billing number located on the statement you received from them. We are unable to adjust these bills or answer questions regarding these charges.

Prescriptions
Please bring a list of your current medications with you at the time of your appointment. Please allow 24 hours for a response to refill requests.

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Patient name (printed):_____ **Patient DOB:**_____

Financial Policy Acknowledgment

I authorize payment of benefits as determined by my insurance carrier directly to the physician. As the responsible party, I agree that I will be responsible for all charges incurred including those amounts not paid by my insurance company. I understand that a $25 fee will be assessed for any payments that are returned for insufficient funds. Also, I authorize the release of medical records, if necessary, for payment by my insurance carrier. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I understand I will be charged for, and hereby agree to pay, all costs and expenses incurred in collecting any past due fees, and interest allowed by law, all without relief from valuation and appraisement laws.

Preauthorization/Card on File Policy

By signing our Financial Policy Acknowledgment you consent to us keeping a credit/debit/HSA card on file to be used for any unpaid balances. You also authorize Hendersonville Dermatology to charge your card in full for any outstanding balances. Charges will only be made after the claim has been adjudicated by the insurance carrier. If the card I give today changes, expires, or is denied for any reason, I agree to immediately give Hendersonville Dermatology a new, valid credit card which I will allow them to charge over the telephone. Even though Hendersonville Dermatology is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented. If you choose not to leave a credit card on file, you have the option to leave a $250.00 deposit with cash or check.

Signature (or guardian): _____ Date: _____
Relationship of guardian to patient: _____

The "Hendersonville Dermatology Office and Financial Policy" has been made available to me and I have reviewed it. I consent to the Preauthorization/Card on File Policy and to charges to my account in accordance with that policy. As the financially responsible party, I acknowledge that I will be responsible for all laboratory/pathology charges. I understand that Hendersonville Dermatology, PLLC has no ability to adjust or modify these charges. _____ ***Initials***

Notice of Use and Disclosure of Protected Medical Information I have read a copy of Hendersonville Dermatology Notice of Use and Disclosure of Protected Medical Information. I understand a written copy will be provided to me at any time upon my request.

Signature (or guardian): _____ Date: _____
Relationship of guardian to patient: _____

Authorization to release information to family members: I hereby authorize Hendersonville Dermatology to release any information from my medical record, which will contain Protected Health Information such as clinical notes, laboratory results and biopsy results, to the individual(s) identified below. Please note that the law does not require the recipient of this information to keep it confidential. Hendersonville Dermatology is authorized to disclose my information to:

_____ Phone number:_____ Relationship to patient:_____
_____ Phone number:_____ Relationship to patient:_____

Signature (or guardian):_____ Date: _____
Relationship of guardian to patient: _____

Medicare Patients Only: The office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require if for the proper consideration of a claim. Please read and sign the following statement: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medical claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment or benefits apply. I also authorize Medicare supplemental benefits, if applicable, be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

Sign name as it appears on Medicare Card:_____ Date:_____