FINANCIAL CONSENT TO PAYMENT POLICY

Thank you for choosing us as your Dermatology/Allergy provider. We are committed to providing you with quality and affordable health care. This document outlines our policy for patient and insurance responsibility for services rendered. Please read it and sign in the space provided. A copy will be provided to you upon request.

1. **PAYMENT** is required for all services at the time they are rendered. All applicable copayments, coinsurances and/or deductibles will be collected at time of service. We accept checks and credit cards. We charge a Return Check Fee of $50.00 per check for any check returned unpaid by your bank for any reason.
2. **PAYMENT PROCESSING.** You acknowledge that all checks received by us are converted into Image Replacement Documents (IRDs) and deposited electronically. This allows you to get a scanned copy of your original check with your monthly bank statement.
3. **INSURANCE.** Your insurance coverage is a contract between you and your insurance company to help you meet medical expenses. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions regarding your coverage.
4. **NON-COVERED SERVICES.** Please be aware that some or all of the services you receive may be non-covered or not considered reasonable or medically necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
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. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company.
6. **REFERRAL.** If your insurance requires a referral from your primary care physician (PCP), it is your responsibility to obtain the referral prior to your appointment.
7. **CO-PAYMENTS AND DEDUCTIBLES.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
8. **NO INSURANCE.** If you have no insurance, you will be required to pay for your visit in full. NOTE: there may be additional charges to your office visit if procedures are required or performed.
9. **PROOF OF INSURANCE.** All patients must complete our patient information form before seeing the provider. We must obtain a copy of your photo ID and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.
10. **COVERAGE CHANGES.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
11. **NON-PAYMENT.** If your account is over 120 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with our Patient Financial Services Department at 844-397-4234. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.
12. **ACCOUNT BALANCES.** For any accounts with credit balances, we will make every effort to refund amounts due back to you as they are identified. For credit balances less than $25, please make a request for refund when you see the credit balance on your statement by calling our Patient Financial Services Department at 844-397-4234. Accounts may assess a $10 statement service fee per month starting at 120 days.
13. **MISSED APPOINTMENT.** If you do not cancel your appointment at least 24 hours in advance, or if you fail to appear for your appointment, we will assess a $25 missed appointment fee. Please help us to serve you better by keeping your scheduled appointment.

We are committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the Financial Consent and Payment Policy of West Dermatology, Las Vegas Skin and Cancer Clinic, North Coast Dermatology and English Dermatology or their affiliates and agents. I understand that charges not covered by my insurance company, as well as applicable copayments and deductible, are my responsibility.

I authorize my insurance benefits be paid directly to the companies of West Dermatology, Las Vegas Skin and Cancer, North Coast Dermatology and English Dermatology or their affiliates and agents.

I agree, in order to service my account or to collect any amounts I may owe, you may contact me by telephone or any number associated with my account, including wireless telephone numbers, which could result in charges to me. You may also contact me by sending text messages or emails, using any email I provide to you. I understand methods of contact may include pre-recorded/artificial voice messages and/or use of an automated dialing service, as applicable. I have read this disclosure and agree that the companies of West Dermatology, Las Vegas Skin and Cancer Clinic, North Coast Dermatology and English Dermatology or their affiliates and agents may contact me/us as described above.

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Print Patient Name	Date of Birth
Signature of Patient or Responsible Party & Relationship	Date