

**Marsh Dermatology, SC**  
**PATIENT FINANCIAL POLICY AND SIGNATURES ON FILE**

**RELEASE OF INFORMATION:** I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payments of medical benefits to the physician.

**PAYMENT POLICIES:**

**1. MEDICARE:** We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible, paying for the co-payment and charges for non-covered /cosmetic services. If we participate with your secondary/supplemental carriers we will file a claim for you. **However, in the event that the secondary does not pay within 60 days, patients will be billed for the balance.**

**2. PATIENTS WITH INSURANCE PLANS THAT ARE CONTRACTED WITH US:** If we participate (are contracted) with an insurance plan under which you are covered, you will be responsible for **any co-pay at the time services are rendered** and we will bill the carrier for all other charges. We will bill both your primary and secondary insurance plans for contracted services (for some commercial plans **co-insurance or unmet deductible will also be due at the time of service**). We make every effort to verify your eligibility and benefits prior to your appointment to determine your responsibility. If the insurance plan determines that there has been an overcharge or undercharge, we will either refund or bill you once we are notified. In the event that we are not aware that a particular service is not covered by your plan, you will be billed for the balance after we obtain a denial from your insurance carrier (the physician will inform you prior to any treatment if such therapy would routinely be considered cosmetic). If there is a pre-existing condition you are responsible for the entire fee.

**3. NON-MEDICARE PATIENTS WHO HAVE INSURANCE COVERAGE WITH A CARRIER THAT WE DO NOT HAVE A CONTRACT (PARTICIPATE) WITH AND UNINSURED:** Patients covered by private commercial plans in which our physician is not a member will be responsible for payment in full at the time of service, regardless of the benefits and payment policies of your carrier. We will *NOT* file claims directly with your insurance company. Patients may elect to independently seek reimbursement from their carrier, if so we can provide you documentation of the services performed.

I have read and understand the financial and office policy of the practice and I agree to be bound by its terms. I hereby authorize Marsh Dermatology, SC to collect financial information arising from my treatment. This includes, but is not limited to, hospital and laboratory services. I also understand and agree that such terms may be amended from time-to-time by the practice.

**ALL PATIENTS:** Our practice sends monthly reminders to patients regarding their outstanding balances. We expect that patients honor these requests in a timely manner. **Outstanding balances must be paid in full prior to scheduling any further services.** Should it become necessary to send more than one statement requesting payment, a \$10.00 service fee will be added to your total bill each month. If full payment has not been received after ninety (90) days your account will be sent to collection and you will be dismissed from the practice. Your account will also incur an additional 35% fee to cover the cost for collection services. Checks returned for insufficient funds will be charged a \$30 bank fee.

**All no-shows or cancellations made less than 24 hours prior to the time of service will incur a late fee of \$50 for office visit and \$100 for surgery or procedure.**

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name \_\_\_\_\_

If you have a **SUPPLEMENTAL POLICY** to which your **MEDICARE** carrier automatically “crosses over”: I request authorized benefits 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 service.

Signature as it appears on Supplemental card \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please present insurance cards and photo ID to the receptionist so copies can be made.**