Dr. Donna A. Serure Dermatology & Cosmetic Laser Surgery, P.C.

Patient Responsibility and Financial Agreement

Thank you for choosing our practice! We are honored by your choice and are committed to providing you with the highest quality medical treatment and care.

We've outlined the information below to help reduce any confusion and/or misunderstanding between our patients, the practice and your insurance coverage. As a service to our patients we will submit your insurance claim to your carrier. If for whatever reason, your insurance carrier denies your claim, we will work with you and your insurance carrier to help resolve or correct the claim for your visit. It is important to inform us if your health insurance plan changes, does not cover a specific service rendered during a visit with one of our providers or if you have a change in your residential address. We are dedicated to providing you with the best possible care and service and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions about this policy, please discuss them with one of our staff or billing manager.

Please initial each paragraph below to indicate that you have read, understand and agree with each of the terms listed below and will comply with fulfilling your financial and legal responsibility to pay for services received.

________Health insurance policies are an arrangement between you, your employer, and your insurance company. We are NOT a party to that arrangement. Our medical services are provided to you with the understanding that you are responsible for any costs regardless of your insurance coverage. Please be aware that not all services are a covered benefit by all Health Insurance plans and may differ by company. It is your responsibility to know that your plan covers both the office visit and any procedures provided by our providers. That your insurance is eligible and in effect and that our doctor participates in your plan (primary, secondary or otherwise). Our staff will assist you to verify that your coverage is enforce based on the information you have provided to us. Ultimately it is your responsibility to know what services are or are not covered by your plan and to notify us if your coverage or company changes. Many insurance companies have additional stipulations that may affect your coverage.

_________You are responsible for knowing, if a **referral is required**. If your insurance plan (E.g. HMO), requires a specialist referral from your primary care physician, you must present your referral to the office staff prior to your visit with our providers. Without the proper written or digital referral, issued by your primary doctor, your insurance plan might not pay for the medical services rendered by our team. Make sure you know what physicians are in your plan, what facilities are covered and what ancillary services you must use. (Such as laboratory, hospitals etc.) If we can be of assistance, please let us know.

_________**Upon check-in**, we will collect any co-payments, prior balances, and payment for any uncovered services and/or your deductible portion as determined by insurance. Our practice is obligated by state and federal regulations to collect your insurance plan's assigned co-pay, deductible and/or co-insurance. Each plan determines its own fee(s). It is your responsibility to provide our practice with your current insurance card information along with your current residential address. Discounting or waiving co-payments, deductibles or co-insurance is prohibited! Emergency services do not require prior authorization. We accept cash, check, and most major credit cards.

_________Outside Laboratory and/or Consultant Fees such as Laboratory, pathology or other consultants may bill you separately for the services they provided you during the course of your care. Your insurance may require a separate co-pay, deductible or co-insurance for any biopsy and/or excision specimen sent to an outside laboratory.

_________We will bill your insurance company on your behalf. If your insurance company does not respond within 45 days, we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance to question why the claim is not paid. Our office will assist you in any way we can.

_________ Cosmetic Procedures require a minimum of a $50.00 deposit at the time of booking your cosmetic appointment. Payment for a cosmetic series and/or balance of your cosmetic service is due prior to the procedure being performed.

_________ We reserve the right to charge a **$40.00** service fee for Medical appointments cancelled with less than **24 hours** notice, and a **$50.00** service fee for Cosmetic appointments cancelled with less than **48 hours** notice. Please contact the office during hours of 9:00 am to 5:30 pm if you should need to cancel. We also reserve the right to charge a **$50.00** fee for any No Show Appointments. Any deposit left on account for cosmetic services may be forfeited as well. Returned checks are subject to a **$35.00** return check fee.

_________Any unpaid charges over 120 days old will be turned over to an outside collection agency with an additional collection agency fee of **$50.00** plus 30% added to your outstanding balance. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patients responsible party, understands that Dr. Donna A. Serure, Dermatology, P.C., has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment(s) for services rendered. The patient, or the patient's responsible party, understands that they are responsible for all costs of collections including, but not limited to; all court costs, attorney fees, and a collection fee of 30% which will be added to the outstanding balance. A late fee of **$10.00** will be added to your balance for every statement sent after the 3rd statement. This agency will report your failure to pay to the THREE (3) national credit-reporting agencies.

_________Self-pay patients (those patients who elect not to carry health insurance) will be required to pay for services received at the time of their visit.

AGREED AND ACCEPTED

By initialing above and signing this form below I understand that I am giving my consent to Dr. Donna A. Serure, Dermatology, & Cosmetic Laser Surgery, PC to use and disclose my health care information to carry out treatment, payment activities and healthcare operations of this practice. I authorize the release of any medical information to my primary care/referring physician, and/or to consultants, if needed, and as necessary to process insurance claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Dr. Donna A. Serure, Dermatology, & Cosmetic Laser Surgery, PC to apply for benefits on my behalf for covered services rendered and request that payment from my insurance company be made directly to Dr. Donna A. Serure, Dermatology, & Cosmetic Laser Surgery, PC.

I further understand that **I am financially responsible** for all services rendered for the following reasons if: **1)** I do not have the proper referral at the time of service, **2)** my referral is invalid/expired, **3)** I have given incorrect/invalid insurance information, **4)** expenses are not covered by my insurance company, **5)** I have not met my deductible, or **6)** the services rendered are deemed medically unnecessary by my insurance company **(this applies to present and future visits)**.

Payment is required for all services at the time they are rendered, including co-payments and any outstanding balances. All optional services will not be performed until a consultation with the Doctor is performed and services to be rendered are explained. **All cosmetic procedures are payable by Cash or Credit Card only.** Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

By signing below, I agree to accept full financial responsibility as a patient (or guardian or as the responsible party for a minor patient under the age of 18) who is receiving medical services from this company. My signature below verifies that I have read the above policies and disclosure statement, understand my responsibilities and agree to these terms.

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SIGNATURE OF PATIENT / RESPONSIBLE PARTY **TODAY'S DATE**