

FINANCIAL POLICY

In order to establish optimal relations with our patients, our financial policies are outlined below.

PPO, OTHER MANAGED CARE, AND MEDICARE PATIENTS: As a courtesy to you, we participate in a number of insurance plans. If you are a member of one of these plans, we will file a claim with your insurance company for non-cosmetic dermatologic services only. We will require you to present your insurance card and picture identification at the time of your visit. Failure to provide an accurate current and valid insurance card and/or referral form will require you to pay in full on the date of service. If your insurance carrier requires a referral form from your primary care provider, this must be presented at the time of service. Please note that it is your responsibility to keep track of referral expiration dates and the number of visits given by your physician.

Your coverage is subject to all of the terms and provisions of your insurance plan applicable at the time services are rendered. We accept payment directly from some insurance companies for non-cosmetic treatments. We will file claims with both your primary and secondary insurance. However, before such claims are filed, coverage will be pre-verified, and you will be asked to pay any unmet deductibles, co-insurance, and co-payments. Please note that copays and unpaid balances from previous appointments are due at the time of service. Non-covered services will not be billed to your insurance carrier, and you are responsible for the cost of these services. It is also your responsibility to update any and all demographic and insurance information and to present a valid and updated insurance card or cards at the time of follow up appointments.

Illinois State Law requires insurance carriers to pay claims within 30 days of receipt. Many insurance carriers have been very slow in reimbursing physicians for services rendered and are therefore not in compliance with these regulations. If we do not receive payment from your primary carrier within 60 days of filing your claim, you will be asked to pay the entire amount.

OUT OF NETWORK AND OUT OF POCKET PATIENTS: If you are not a member of one of the insurance plans with which we are contracted, please note that payment for all services is due at the time of service. Many insurance plans do provide reimbursement for services provided by a physician who is out of network. It is your responsibility to contact your insurance carrier to verify these benefits and to submit a claim form to your insurance company. Our office can provide you with a copy of the charges for your visit to submit to your insurance company.

COSMETIC PROCEDURES AND PRODUCTS: Fees for all cosmetic procedures and products are due at the time of service. As these procedures and products are not medically necessary and are not covered by your insurance plan, charges for these services and products will not be filed with your insurance company. If appointments for cosmetic procedures are missed cancelled or changed less than 48 hours (2 business days for Monday appointments) prior to the appointment time, you will be responsible for 50% of the amount of the cosmetic procedure.

MISSED APPOINTMENTS: We make every effort to accommodate patients at the earliest opening in our schedule. When appointments are missed, this inconveniences patients, like yourself, waiting to see the doctor. Please notify the office 2 business days prior to your scheduled appointment if you will be unable to keep your appointment. If you miss, cancel or change a follow up appointment less than 48 hours (2 business days for Monday appointments) prior to the appointment time, you will be charged a \$25 cancellation fee for general dermatology appointments, and \$100.00 fee for any surgical procedure appointments.

OUTSTANDING BALANCE: You are responsible for all charges for services that you receive. If the patient responsibility portion of your charges, including charges applied to your deductible and/or coinsurance is not paid in full within 30 days following the receipt of the patient responsibility statement mailed from our billing office, your account may be turned over to a collection agency. If any balance is not paid when due, you are responsible for all costs of collection, including attorney fees, court costs, and collection agency fees.

RETURNED CHECKS: There will be a fee of \$30 for all returned checks.

I understand the above financial policies and agree to comply with these policies. I authorize the payment of medical benefits for myself (or my dependents) directly to Lake Shore Dermatology for professional services rendered. I permit a copy of this authorization to be used in place of the original.

Patient/Guardian signature

Date