FINANCIAL POLICY

INSURANCE BILLING

- ***Because your health insurance policy is a contract between you and your carrier, it is imperative that you research your coverage benefits before your visit.*** *Due to the number of plans and coverage options, we cannot provide individual policy benefits information. We are contracted with many insurance carriers but may not be contracted with your individual plan or group. Ultimately, all charges are the responsibility of the patient or his/her guardian.* ***_____ initial***
- *We will submit claims to your insurance carrier (primary and secondary) as a courtesy. In order to do so, we require you to present your insurance card at the time of service.* ***Your co-pay and any applicable deductible are due at the time of service unless special arrangements have been made prior to your visit.*** *If we do not receive a copy of your insurance card, we will request payment in full at the time of service.* ***If, for any reason, your insurance carrier has not paid their portion of the charges within 60 days of the date of service, you will be responsible for payment in full.*** *Outstanding balances unpaid beyond this period will be subject to collection services.* ***_____ initial***
- ***If you do not have any health insurance, we will request payment in full at the time of service.*** *We do extend a 10% discount to uninsured patients who pay in full on the day medically necessary services are provided. (This discount is not applicable to patients who have high deductible policies as they will automatically receive a discount based on our contracted rate with their insurance company.)* ***_____ initial***

OUTSIDE SERVICES

It is customary for Deschutes Dermatology Center to send specimens to outside sources for processing. Common examples of these services are pathology and laboratory testing. Should such services be needed in the course of your care, you will receive separate billing statements from these outside sources. ***These charges will be in addition to those for services rendered directly by Deschutes Dermatology Center. _____ initial***

ELECTIVE SERVICES

Only medically necessary procedures will be billed to the insurance carrier. ***You are financially responsible for all charges associated with elective, cosmetic and non-covered services or treatments. Payment in full is expected and the time of service. _____ initial***

APPOINTMENT CANCELLATIONS

We ask that you provide twenty-four hour notice for cancellation or rescheduling. If a least 24 hour notice is not provided, you will be charged a flat fee of $25 for a missed office visit. Missed cosmetic visits will be subject to forfeiture of the deposit. ***_____ initial***

LATE CHARGES AND OTHER FEES

- *Accounts with balances over 60 days old are subject to late fees.*
- *Accounts referred to a collection agency will be subject to a $50.00 collection fee, attorney fees and/or the percentage allowed under Oregon state law.*
- *There is a $35.00 fee for all checks returned for NSF (non-sufficient funds)* ***_____ initial***

Patient Signature: _____ ***Date:*** _____

Parent/Guardian (please specify) signature required for minors

Printed Patient Name: _____ ***Date of Birth:*** _____

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DESCHUTES dermatology center