

Moeller Dermatology, LLC
Patient Financial Policy

Thank you for choosing the office of Moeller Dermatology as your dermatology care provider. Our primary mission is to provide our patients with outstanding medical care. We are committed to providing state of the art treatment and care for disorders of the skin, hair and nails. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Carefully review the following information and return this form with your signature and today's date. Please ask if you have any questions about our fees, our policies and/or your responsibilities.

We request all patients complete our Patient Information Form prior to seeing the provider. Please notify our office of any patient information changes (i.e. address, name, insurance information, etc).

We accept cash, checks, MasterCard, Visa or Discover. Your bill might include office visits, destructive treatments, biopsies, injections, removals of benign/malignant lesions, pathology, laboratory, or other charges. You may also receive bills from outside pathology and laboratory clinics that we utilize, as well as other physicians and/or surgery centers if your procedure is not performed in our clinic. As a courtesy to you, we file your claims to your insurance company. Amounts not covered by your insurance are your responsibility. Please inquire with the business office about our indigent care and cash discount policies for medically necessary (non-cosmetic) services. **ALL CO-PAYMENTS MUST BE PAID AT THE TIME OF SERVICE. IF YOU DO NOT HAVE INSURANCE, PAYMENT IN FULL IS EXPECTED AT THE TIME OF YOUR VISIT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. ALL COSMETIC PROCEDURES PERFORMED BY A MEDICAL PROVIDER MUST BE PAID AT THE TIME OF SCHEDULING.**

INSURANCE:

It is the patient's responsibility to provide the clinic with current insurance information. Our relationship is with YOU, not your insurance company. Kansas's law states that clean insurance claims should be paid within 30 days from receipt (K.S.A. 40-2442). Please call your insurance company if your bill is not paid promptly. Surgery patients who do not have insurance must make payment/payment arrangements prior to surgery. Our staff will estimate your surgical and laboratory fees. If your insurance company requires use of a specific lab, it is your responsibility to notify us. Please check with your insurance company to ensure our providers participate with our network. Failure to honor any agreements may result in your account being placed with a collection agency. We do not accept workers compensation claims.

REFERRALS:

If you have an insurance plan that requires you to have a referral to be seen in our office, it is your responsibility to obtain a referral from your primary care physician and ensure our office has current copy. If our office does not have a current referral on file, you will need to sign a self-referral form at the time of your appointment stating that you will be responsible for payment in full for that days services. If you do not wish to sign a self-referral, you may be asked to reschedule your appointment until you can get a referral from your primary care physician.

MINORS:

The parent/guardian that signs this Patient Financial Policy will receive the billing statements for the minor and will be responsible for payment on the minor's account.

MISCELLANEOUS FEES:

Missed Appointments: If you fail to cancel your surgery (including excisions, Mohs) appointment prior to 24 hours of the time the surgery is scheduled, you may be subject to a \$100.00 fee. If you fail to cancel your clinical appointments prior to 24 hours of the time your appointment is scheduled, you may be subject to a \$50.00 fee. Fail to cancel laser appointments will lose professional fee.

Form Completions: There is a fee of \$10.00 to complete skin cancer policy claims forms and disability claims forms. **These fees must be paid in full before the service will be performed.** Please allow one week for completion of any forms. **Multiple Billing:** A fee of \$5.00 will be billed for each additional statement over two statements sent. **Copay Surcharge:** A \$15 fee will be attached to account if copay not paid within 7 days of the appointment. **Returned Checks:** There is a \$25.00 fee for any check returned for insufficient funds. **Payment Plans:** All accounts over 120 days including payment plan accounts will be assessed 10% interest annually.

ONE TIME AUTHORIZATION:

I request that payment of authorization Medicare Benefits be made either to me or on my behalf to Moeller Dermatology, L.C.C. for any services furnished to me by the physician. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I hereby assign payments directly to the above physician for the Surgical and/or Medical benefits, if any, otherwise payments to me for services, I understand I am financially responsible for charges not covered by my insurance. I also understand that regardless of insurance coverage, I am financially responsible for all services rendered.

INSURANCE INFORMATION RELEASE AUTHORIZATION:

I hereby authorize the above physician to release any information acquired in the course of my examination or treatment to my referring doctor and/or my insurance company.

PHOTOGRAPHS:

I understand that photographs taken before, during, or after the procedure may be used for documentation or teaching purposes.

I have read and understand the Financial Policy/One Time Authorization and realize this policy is subject to change without notice:

Patient Name

Patient/Responsible Party Signature

Staff Signature

Date