

IDAHO DERMATOLOGIC SURGERY AND LASER CENTER
OFFICE FINANCIAL POLICY

(Please and use black ink only)

Patient Name: _____ Date of Birth ____/____/____

Dear Patient:

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

1. If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill your carrier for all the charges that are covered, i.e., medically necessary services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for payment of:
 - a. The annual deductibles
 - b. Co-payments / co-insurance
 - c. Charges for non-covered or cosmetic services*

*If you have Medicare you will be asked to sign an Advanced Notice of Liability Form in the event that a service is provided which we know is not covered by Medicare.

If a charge or procedure is not covered by your insurance you, the patient, will be responsible for all remaining balances after we receive a denial from your insurance carrier.

2. For patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:
 - a. We will file both your primary and secondary insurance. If we do not receive a payment from your primary carrier within 60 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.
 - b. If we receive payment from the primary insurance carrier, we will file a claim with your secondary insurance carrier. If we do not receive payment from your primary carrier within 60 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.
 - c. If you only have primary insurance (e.g., no secondary/supplemental coverage), a partial payment will be due at the time of service. Any amount not paid by your insurance company will be billed to you. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. After your primary carrier has paid, the remaining balance will be billed to you and is due and payable 10 days after receipt of the statement.
 - d. It is the patient's responsibility to verify whether or not we are contracted with their insurance company.
3. If your insurance deductible has not been met, you may be required to pay your full deductible at time of service (depending on your procedure).

All unpaid account balances remaining after 60 days will accrue interest at a rate of 18% annually.

If your account is turned over to collections, you will be responsible for any attorney, legal, or collection fees, which will result in an increase of 30-50% of your initial balance.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient Signature

____/____/____
Date