DERMATOLOGY
Healthcare Excellence

FINANCIAL AGREEMENT

Date: _____

Thank you for choosing Dermatology Healthcare Excellence for your skin care needs. We are pleased to welcome you to our practice. Our chief concern is that you and your family receive the finest care in maintaining healthy skin. Please be advised that you, as the patient or guardian/guarantor, are responsible for understanding your insurance plan and meeting all requirements to fulfill contractual agreements between your plan and our practice. If you feel you are unaware of your plan's co-pays, deductibles, or co-insurance, we ask that you kindly reschedule your appointment until you completely understand your financial responsibility.

We will be glad to submit your claims to your insurance carrier for payment as long as we are a contracted participant with them. However, the final responsibility of payment due for services rendered belongs to you. Prior authorization approval does not guarantee payment of services and if a referral is required from your insurance carrier, medical group, or primary care physician, you will be responsible for obtaining one prior to your visit. You are responsible for all charges not paid by the insurance company. At the time of visit, please present all necessary information to avoid non-payment by the insurance carrier, which includes the insured party's demographic information, current insurance card(s), any required insurance referral, and accurate completion of the registration paperwork.

If we do not participate with your insurance carrier, payment in full is due at the time of service.

Some procedures may be deemed "not medically necessary" or "cosmetic" and therefore not payable by your insurance carrier. If this is known prior to the procedure, then a staff member will notify you of your financial responsibility before performing such procedure. Although we make every effort to forewarn patients of non-coverage, it is impossible to know all procedures that all insurances will consider cosmetic. In those instances where a procedure is deemed medically unnecessary by your insurance carrier, you are still financially responsible for the cost of the visit even if it was not discussed at the time of the visit.

All pathology (i.e., biopsy), blood, urine, and microbial (i.e., culture) diagnostic tests are billed separately from our office and are the responsibility of the patient. Our staff will do its best to identify which lab your insurance plan or medical group is contracted with. Please ensure you present the correct information to identify the proper handling of any testing.

We require a 48 hour notice of cancellation of your surgery or cosmetic appointment and 24 hour notice for all new and return appointments. Otherwise you will be subject to a missed appointment fee of $200 for surgery appointments and $50 fee for all new and follow up general dermatology appointments.

Any medical necessity forms/letters required by your insurance company or any communication outside the usual and customary forms required for billing or communication with other physicians or providers will be subject to a $35.00 administrative fee. As a courtesy to patients relocating out of the area, we will be happy to supply your new dermatologist a copy of your medical records at no charge. Any other requests for copies of medical records will be subject to charges as dictated by Colorado state law.

We accept payment in the form of Venmo, Zelle, check, debit, or credit card. We do not accept cash. Returned checks are subject to a $35.00 service charge and any cancellation of product will incur a 20% fee. We understand that occasionally some of our patients will experience financial difficulties. Please bring these situations to the attention of our billing department or office manager to allow us to help manage your account in the most effective way. Failure to pay moneys owed for services may result in submission to collections or patient dismissal from the practice.

CONSENT

I, the undersigned, accept financial responsibility for payment of all services rendered by Dermatology Healthcare Excellence. I understand and agree to abide by the above-stated terms and conditions. I authorize benefits and payment to Dermatology Healthcare Excellence.

_____	_____	_____
Signature of Patient or Guardian	Print Name	Date