Dermatology Associates of Tallahassee Dermatology SouthEast

Dermatology Associates of Tallahassee & Dermatology Southeast Financial Policy

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. Please review the terms of our financial policy carefully before signing the following page.

Insurance Guidelines:

Your insurance is a contract between your insurer and you. It is your responsibility to know and understand the terms, guidelines, and limitations of your plan. Deductibles, coinsurance, and copayments are the responsibility of the policy holder at the time of service. It is also your responsibility to advise us of any changes in your insurance, your address, or your employer.

If you are on traditional Medicare or are a member of a health plan within our network, we will submit your claim to your insurance company. Our office will make two (2) attempts to settle any outstanding bills with your insurance company. If your insurance deems a service "not a benefit" or a "non-covered service," you will be responsible for and you expressly agree to pay the balance of such non-covered services.

Claims and Payments:

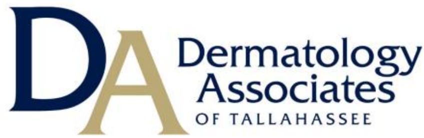
I. **Secondary/Supplemental Insurance Plans.** We are happy to file secondary and supplemental claims as a courtesy. In the case of non-contracted secondary carriers, the balance will become patient responsibility 30 days after that claim is filed.

II. **Non-Contracted Insurance Plans**. If we do not participate with your insurance carrier, payment in full will be required by you at the time services are rendered. Our billing department will file a claim to your insurance company as a courtesy to you upon request.

III. **Minors**. A parent or legal guardian must accompany all patients under the age of 18 to all appointments. If this is a custodial parent, we can submit the charges to another parent’s insurance. However, the parent presenting the child for care will be billed for the balance not covered by insurance.

Medical Records:

Copies of pathology reports are provided to you or another physician at no charge. Any additional medical records requests and/or completion of forms (e.g., disability, life insurance, cancer policies, etc.) are subject to processing fees determined by state law and contractual agreements. Please be advised that medical records requests require time to be processed and cannot be provided the same day requested.



Dermatology SouthEast

Pathology Procedures:

Dermatology Associates of Tallahassee & Dermatology Southeast have an on-site lab and pathologist who perform the slide preparation and interpretation of our patients' biopsy specimens. Fees associated with this service are separate from the procedure performed by your provider.

Your provider may send the specimen to an outside lab for slide processing and interpretation. In those instances, patients or their insurance will receive a bill from the outside lab.

Dermatology Associates of Tallahassee & Dermatology Southeast providers reserve the right to send their patients' specimens to the most qualified dermatopathologist of his or her choosing. Therefore, if your insurance requires the use of a specific lab, it is your responsibility to provide us with that information prior to being seen. Failure to do so may result in additional out-of-pocket costs to you.

Cosmetic Services:

Patients are financially responsible for all cosmetic procedures at the time of service. This office does not bill insurance companies for cosmetic procedures.

Collection Fees:

Statements are sent out monthly for patients with personal balances. Payment is due upon receipt of the statement. If you are unable to pay the balance in full, please contact our billing department. Personal balances over 90 days from the date of service will be sent to our collection agency. In the event an account is turned over to an outside collection agency, patients will be responsible for any collection fees incurred, including court costs, attorney fees, and collection agency charges.

Returned Check Fee:

If a check is returned for insufficient funds, a $35 fee will be added to your account balance. This total must be paid by cash or credit card within 14 days.

Acknowledgement of Policy

My signature below indicates that I have read, understand, and will comply with the information contained within this financial policy. A copy of this policy is available upon request.

______________________________________ ________/________/_______
Signature of Patient or Legal Representative Date

______________________________________ ___________________________
Printed Name of Patient or Legal Representative Relationship to Patient