Dermatology of Cape Cod, PC Financial Policy

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

- **Insurance:** I agree to furnish ***DOCC, PC*** with a copy of my current health insurance card(s). I also agree to provide an explanation of benefits and/or claim form(s) from my insurance company, when applicable. A copy of my insurance card(s), front and back will be kept on file. The card must be up to date. If **DOCC, PC** cannot confirm that my policy is in effect, I may be asked to reschedule my appointment or pay in full for services provided.
- I hereby authorize the release of pertinent information to insurance carriers and authorize my insurance benefits to be paid directly to **DOCC, PC**.
- I understand that ***DOCC, PC*** will bill my health insurance company and will refund any overpayment on my account to the appropriate party (i.e., insurance company, patient). Your insurance is a contract between you and your employer or you and your insurance company. **DOCC, PC** is not a party to that contract. Different policies cover different services. Furthermore, some insurance companies select those arbitrarily. Therefore, it is incumbent upon each patient to familiarize themself with his or her policy.
- I understand that ***DOCC, PC*** allows 30 days for the processing of my claim by the insurance company. In the event the practice does not receive reimbursement within 45 days, I will be responsible for payment.
- I will notify the **DOCC, PC** billing department if I am aware of a payment delay by my insurance company. The billing department will provide me with assistance in resolving the claim.
- **Co-payment:** I understand that co-pays are due at the time of service and must be paid before I see the doctor or have my prescribed treatment. If I arrive for my visit without my co-pay, I may be asked to reschedule my appointment per contract with my insurance company.
- Any co-insurance, deductible, out of pocket and co-pay amounts will be my responsibility. Any balance left after my insurance has paid must be remitted within 30 days or each month an interest charge will be applied to my account of $10 or 10% whichever is greater. In the event I am unable to pay my responsibility in full, I will contact the billing department to discuss financial arrangements.
- **Deductibles:** If I have a deductible, I will be required to pay a percentage of the cost of my visit before I leave the office.

- **Referrals:** If my insurance requires that I have a current referral to be seen at **DOCC, PC** I must obtain one prior to my visit, otherwise I will be responsible for the full cost of my visit per contract with my insurance company.
  - **Patient Balances:** I agree that I will be responsible for balances applied to my account that are not covered by my health insurance plan. Outstanding patient balances not paid within 60 days of first billing will be sent to collections. In the event my account is turned over to an outside collection agency, I agree that I will be responsible for a fee of $50 by ***DOCC, PC,*** as well as any and all attorney fees, court costs, etc.
  - **Non-covered Services:** Services considered non-covered or cosmetic in nature will be my responsibility and will be paid in full at the time of service.
  - **Returned Checks:** I understand that my account will be charged $35 in addition to the original amount of my check when a check presented for payment is returned and marked “non-sufficient funds” (NSF). Returned checks over $500 will be incur a $50 fee in addition to the amount of the check.
  - If you plan to pay privately for your services, please be advised that it is **DOCC, PC** policy to collect payment in full at the time of service. If you are unable to make payment in full at the time of service, your appointment will be rescheduled to a more convenient time.
  - **Missed Appointments:** Missed appointments will incur a $50 fee. Twenty-four hour notice is required to cancel an appointment without a fee.
  - A summary of my visit will be made available upon request within three business days of my visit.

I acknowledge that I have received a copy of this financial policy. I have read, understand, and agree to the insurance assignment and financial policies stated above. I agree to comply with the terms set forth for services rendered by **DOCC, PC.**

DOCC, PC must emphasize that as medical care providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date services are rendered.

Patient/Responsible Party Signature _____ **Date** _____