DARST DERMATOLOGY, PC FINANCIAL, RELEASE OF INFORMATION and PRIVACY (HIPAA) POLICIES

Thank you for choosing Darst Dermatology, Inc. for your dermatology health care. Our main concern is that you receive the proper and optimal treatment needed to restore your health.

Please understand that processing your claim and payment of your bill is considered part of your treatment. So that we may better serve you, we ask you to please read, sign and return this form to us prior to your treatment. If you have any questions or concerns regarding our payment policies, please do not hesitate to discuss them with our practice administrator, Sandi Darst.

All patients should provide **accurate and complete** insurance information prior to being seen by the doctor. We will ask that you present your insurance card upon check in at each visit so that we can verify coverage and the appropriate co-payment.

- Co-payments for office services are required at the time you check-in. If co-pay balances are not paid on the date of service, we may need to reschedule your visit date.
- We accept cash, check, debit cards, Visa, MasterCard and Discover.
- We will file your insurance claims for services. Once applicable insurance has paid, any remaining balance will be the responsibility of the patient due within 10 days.
- For high deductible or co-insurance plans, we request payment of your portion or percentage at the time of service, unless payment arrangements have been previously agreed upon.
- For services determined not covered by insurance, we require payment in full unless arrangements have been established before the visit.
- If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined herein.
- Lab tests and/or pathology specimens sent to outside laboratories will be billed separately from Darst Dermatology's charges. The laboratory service will bill independently for their charges.

Missed Appointments: Please help us serve you and our other patients by keeping all scheduled appointments. If you must change an appointment, please do so within 24 hours of the appointment time. Failure to notify of your cancellation will result in a $45.00 charge to your account.

Referrals: It is ultimately the patient's responsibility to bring any required referrals for treatment at, or prior to, the time of your visit. If you do not have a referral, your visit will be rescheduled, or you may be financially responsible.

Returned Checks: For checks returned to us as unpaid by your bank, we will charge you a $35.00 fee along with fees charged to us by the bank.

Past Due Accounts: Overdue accounts will be referred to a collection agency 60 days past due. If your account goes to collection, you agree to be responsible for all fees involved in the collection process.

I certify that I have read and understand the "Financial Policies" and agree to all terms and conditions as stated above. I certify that the information that I have given today is correct to the best of my knowledge. I understand that it is my sole responsibility to verify insurance coverage and I also understand that it is my responsibility to inform Darst Dermatology, PC of any changes associated with my insurance status. I agree to make in-full prompt payment to Darst Dermatology when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. I hereby assign and direct to pay any and all benefits for medical services under this claim to Darst Dermatology, PC.

I authorize the release of any medical information to my primary care or referring physician, to consultants if needed, and as necessary to process my insurance claims and prescriptions. I authorize the use of this signature on all my insurance claims.

Darst Dermatology has my authorization to charge my credit card for any current or past due personal balance(s) upon receiving my verbal or written permission.

Patient Signature: ______________________________ Date: ______________________________

FOR MEDICARE PATIENTS

We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% copayment. We do file with secondary (supplemental) carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed.

I authorize assignment of Medicare benefits to Darst Dermatology, PC. for any services furnished by Dr. Darst. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits payable to related service. If "the other health insurance" is indicated in box 9 of the HCFA 1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I understand my signature authorizes release of medical information necessary to pay the claim.

Patient/Responsible Party Signature: ______________________________ Date: ______________________________

Privacy Practices (HIPAA)

By signing below, I acknowledge that I have read and understand Darst Dermatology's Notice of Privacy Practices. This document is posted on our website and is always available at the check-in desk.

Signature: ______________________________ Date: ______________________________