DARST DERMATOLOGY

FINANCIAL AND PRIVACY/HIPAA POLICIES

Thank you for choosing Darst Dermatology 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. If you have any questions or concerns regarding our payment policies, please do not hesitate to discuss them with our practice administrator, Gail LaBarr.

All patients must provide **accurate and complete insurance information** prior to being seen by the doctor. You must present your insurance card and photo identification upon check in at each visit so that we can verify coverage and the appropriate co-payment. Failure to do so will result in your appointment being rescheduled.

- 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 your visit will be rescheduled.
- We accept cash, debit cards, Visa, MasterCard, Discover and checks.
- We will file your insurance claims for services. Once applicable insurance has paid, any remaining balance will be the responsibility of the patient, due immediately.
- We file any Secondary Insurance as a convenience to you. If your Secondary Insurance does not pay, any remaining balance will be the responsibility of the patient due immediately.
- For high deductible or co-insurance plans, we require payment of your portion or percentage at the time of service.
- It is your responsibility to provide any documentation to your insurer for coordination of benefits. If you fail to do so within 15 days of being notified, you agree that you will pay the entire balance immediately.
- For Cash Paying / Uninsured patients: The entire bill is due at the time of service.
- Surgical appointments require a cash deposit, which is non-refundable if cancelled within 3 business days of the appointment.
- For services determined not covered by insurance, we require payment in full at the time of service.
- For Medicare Patients **without** secondary insurance: 20% of the estimated allowable charges is due at the time of service.
- For Medicare Patients **with** a secondary insurance: A bill will be sent after your secondary insurance processes the claim.
- For Medicare Patients who have not met the yearly deductible, the remainder of the deductible is due at the time of service.
- 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.
- We are not a Medicaid provider. The patient is responsible for any amount due.

Missed Appointments: Failure to notify of your cancellation 24 hours in advance or failure to show for an appointment will result in a $45.00 charge to your account.
Referrals: If your insurer requires a referral for treatment, you must 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 or small claims court that are 60 days past due. If your account goes to collection, you agree to be responsible for all fees involved in the collection process. 10% Interest will be charged on accounts not paid within 30 days.

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Copayments, Coinsurance and Deductibles: Your contract with your insurance company dictates your portion of the bill. Our agreement with your insurer(s) dictates the contracted rate and that we collect the full amount of the Copayment, Coinsurance, Deductible and Patient Responsibility portions of the bill and that we may not waive these fees. These fees are due at the time of service. This notice supersedes any other prior or future offer of waiver either verbal or implied you feel you received or that you have/had with another physician.

Updates to Policies: Darst Dermatology, PC reserves the exclusive right to update or otherwise modify its Financial Policies. Updates and modifications are binding and supersede any previously published policies. The most current version is available on our website www.darstderm.com or on the secure Patient Portal.

FOR ALL PATIENTS

Financial- I certify that I have read and understand the Financial Policies and agree to all terms and conditions as stated above. 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.

Patient Signature: _____ ***Date:*** _____

Privacy Practices/HIPAA- By signing below, I understand that I have the right to revoke this authorization at any time by sending a written notification to: **11301 Golf Links Drive, Suite 203 Charlotte, NC 28227**. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. This authorization shall be in force and in effect until the requested items have been delivered or the information has been reviewed by the patient. I acknowledge that I have read and understand Darst Dermatology's Notice of Privacy Practices. This document is posted on our website and is available at the front desk.

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 30 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 Signature: _____ ***Date:*** _____