TEXAS DERMATOLOGY & SKIN CANCER CENTER

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FINANCIAL DISCLOSURE POLICY

Thank you for choosing Texas Dermatology & Skin Cancer Center, PLLC for your dermatologic care. In order to minimize confusion and misunderstanding between our patients and the practice, we have adopted the following financial policies. If you have any questions about our policies, please discuss them with one of our staff members.

We are dedicated to providing you with the best possible care and service and we regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

General

Your insurance policy is a contract between you and your insurance company only. If you fail to notify our practice of any insurance change(s), you are fully responsible for any amount not paid by your insurance company. Each health plan varies with regard to deductibles, co-payments, and co-insurance. Terms are contracted between the insurance company and the patient at the time you accept the insurance. It is your responsibility to be aware of your deductibles, co-payments, and co-insurance, and it will be your obligation to remit all appropriate payments as outlined in your insurance policy.

Insurance policy requirements do not allow our practice to absorb any co-payments, coinsurance, or deductibles.

All deductibles, co-payments, and co-insurance are due at the time of service.

NO Refunds are provided on ANY services rendered and/or products purchased.

HMO / PPO / Other Insurance Coverage

If you have insurance through a company we have contracted with, we will require a copy of your insurance card and a current/valid driver's license. All co-payments are due prior to seeing the physician on the day of visit. If your insurance carrier requires a referral from your primary care physician, this must be present at the time of service. Failure to provide all necessary information may require you to pay in full on the date of the visit. It is your responsibility to keep track of the referral expiration dates and the number of visits given by your primary care physician. You will responsible for all deductibles, co-insurance, co-payments, and any services denied by your insurance carrier as not medically necessary and/or not covered.

Medicare

Our physicians are participating Medicare providers and accept Medicare assignment as of June 2011, which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowable charges after you pay for your annual deductible. You are responsible for any amounts applied to your deductible and the 20% co-insurance. If you have a secondary insurance, as a courtesy, we will submit any remaining balance to that particular carrier. You will be responsible for all deductibles, co-insurance, copayments, and any services denied by your insurance carrier as not medically necessary and/or not covered.

Laboratory
Depending on your insurance carrier's policy, you may be required to pay a separate co-payment for any specimen taken during your visit.

Self-Pay Patients
For patients with no insurance, the guarantor is responsible for the bill at the time of service.

Cosmetic Patients
Cosmetic procedures will not be submitted to your insurance company. Payment is due at the time of service.

Minor Patients
For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred during the visit.

Payments
Payments can be made by cash, check, VISA, or MasterCard. Patient balances are due immediately upon receipt of statement. NO refunds of ANY kind are provided.

Returned Checks and Collections
A charge of $35 will be applied for all returned checks. In the event that any action is brought to collection, I agree to pay any reasonable collection costs and/or attorney fees. My signature below indicates my understanding and full responsibility for the balance on my account for any professional services rendered at Texas Dermatology & Skin Cancer Center, PLLC

No Show Fee
We understand that you may have to cancel your appointment. We ask that you kindly give us 24 hour notice. In an event you fail to notify us, Texas Dermatology and Skin Cancer Center, PLLC will charge you a fee of $35.

I have read and fully understand ALL of the information listed above.

Printed Name (First, Middle, Last): _____

Signature: _____

Date: _____/_____/_____

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Texas Dermatology & Skin Cancer Center, PLLC / Avani Bhambri MD / Sanjay Bhambri DO for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-payments, deductibles, and non-covered services are due in full at the time of service.

Signature of Responsible Party: _____ **Date**: _____/_____/_____

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: _____ **Date**: _____/_____/___