DERMATOLOGY & COSMETIC CENTER

FINANCIAL POLICY

Thank you for choosing Mays Dermatology & Cosmetic Center. We are committed to providing you with the highest quality care. Please read and make sure you understand the entire agreement. A CURRENT GOVERNMENT ISSUED PHOTO ID AND INSURANCE CARD (IF YOU ARE REQUESTING US TO BILL YOUR INSURANCE COMPANY) are **REQUIRED EVERY VISIT.**

APPOINTMENTS

Whether booking online or via phone, a valid credit or debit card is required to book an appointment. Your card will be charged a no-show fee if your appointment is cancelled or rescheduled less than 24 hours prior to your appointment time for ANY reason. All cancellations must be performed via our online system or with one of our staff members. If you arrive after your scheduled appointment time, you may be rescheduled. Surgery appointments require a refundable deposit prior to scheduling. Deposit is refunded if surgery cancelled or rescheduled within 7 business days of date.

PAYMENT AT TIME OF SERVICE

Based on your specific insurance benefits, all or part of your visit and/or procedures may be your responsibility. Payment for visit and additional procedures is collected at time of service. After your claim is processed, you may owe additional fees based on your exact coverage and in/out of network status. If no insurance or no proof of insurance, full payment for all services rendered is expected at time of service. All co-payments and deductibles must be paid at the time of service. Due to increased high deductible plans your credit card information will be stored in our HIPPA secure system. **Your payment on file will be charged automatically for any immediate due payment on your date of service and/or any remaining patient balance up to 30 days after your account has been updated.**

*** Insurance:** We participate with most plans. If your coverage can not be verified by our office for any reason, or we do not participate with your plan, you will be treated as a CASH PAY patient and will be responsible for full payment of all rendered services. In this case, you will be responsible for filing any claims with your insurance plan if you wish and we are happy to provide you with medical records. Knowing your insurance benefits and in/out of network status is YOUR responsibility. Our practice does NOT guarantee benefits, coverage, in-network status, and/or fees with ANY insurance plan as these are subject to change at any time. Patients must provide correct insurance information, any changes, and/or a current referral when/if required. Should your insurance require further paperwork for approval of certain procedures/services, a documentation processing fee may be applied. Claim refunds are processed 30 business days after receipt of EOB by billing company. Refunds will not be processed until all future or outstanding claims have been addressed.

*** Non-covered services/Denials:** All non-covered services or denials for any reason are due and payable at the time of visit and the PATIENTS FULL RESPONSIBILITY. If your insurance requires a referral/PA for coverage of any services, you may be responsible for up-front fees until proper needed documentation is received. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If we have to reprocess your claim for any reason, you may be responsible for amount due until your claim is successfully processed. Billing is handled by an independent billing company. All questions or concerns regarding your bill/statement must directed to the billing company directly.

***Nonpayment:** Please understand that payment is an integral part of your treatment. If your account is over 30 days past invoice date, interest will incur (1.5%) minimum $2 daily. If a balance remains unpaid more than 45 days, your account will be sent to a collection agency and you may be discharged from the practice. In the event that Mays Dermatology refers your account to a collection agency, you understand that you are responsible for and agree to pay all fees, collection fees and legal fees, incurred with settlement of your delinquent account. Any account with outstanding balance more than 90 days for ANY reason will not be scheduled until account fully paid and resolved.

***Minor patients:** Minor patients MUST be accompanied by a parent or legal guardian. The parent/legal guardian accompanying the minor during the first visit will be considered guarantor of the account and therefore accepts full financial responsibility of all services rendered on the minor's behalf to be charged to their account.

*** COSMETIC & CASH pay patients**: Full payment for all cosmetic procedures, products, and/or cash pay services is due at time of service. For procedures that require blocking of staff time and disposable/supply purchase, payment is required at time of scheduling the procedure. All cosmetic procedures and product sales are FINAL SALE. No returns or exchanges.

We do not accept checks for cosmetic/cash pay purchases. For your convenience we offer CareCredit.
Disclosure: Mays Dermatology, PLLC has an affiliation and financial/ownership interest in ADG Medical, PLLC, affiliated with ADG Houston Path PLLC DBA Medical Pathology Associates, to which you may be referred for pathology services. A copy of this notice will be maintained with your medical records. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy.

*In the event of a returned check for any reason, a fee of $30.00 will be charged to your account.

I have read and fully understand the above financial policy. I agree to abide by the above guidelines and my signature below confirms this. I agree to allow Mays Dermatology & Cosmetic Center to securely store and charge my credit card on file for any due balances and fees on my account or account of my minor child for services performed. I agree that I will be responsible for all due fees and charges including credit card chargeback fees pertaining to this agreement.

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Signature of patient or responsible party **Date**

HIPAA

I have read and understood the Notice of Privacy Practices. (full detailed version is found on website www.maysderm.com) and consent to our use and disclosure of protected health information about you for the purpose of treatment, coverage, and payment from your health insurance company.
I will list the names and relationships of persons with whom we may discuss your medical care (if any) and whether messages can be left on your phone on the new patient packet that is provided.

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE
I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims.

Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits. In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

AUTHORIZATION FOR TREATMENT

I authorize examination, diagnosis, and general treatment (including, but not limited to, the use of skin biopsies, labs and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of Mays Dermatology & Cosmetic Center, PSC. I understand that any treatment/procedure other than an Office Visit (such as Liquid Nitrogen and biopsy) may not be covered under my co-pay but might be applied to my deductible**. I realize that if a medical procedure such as a biopsy or surgery is required, I will be given additional information. IN THE EVENT THAT A BIOPSY IS PERFORMED I understand and consent to the following:**
I may be responsible for a separate fee related to processing and examination of my tissue specimen(s).
Tissue specimen(s) will be sent to a laboratory for analysis to confirm a diagnosis. Furthermore, additional costs may be incurred for consultation fees and from additional special studies if indicated. Any additional questions or issues must be addressed with my insurance carrier. I am responsible for all costs which are not covered by my insurance plan. if I do not have insurance coverage, I assume all financial responsibility with laboratory fees.

ADDITIONAL AUTHORIZATION FOR THE MEDICAL TREAMTENT OF A MINOR/CHILD
I hereby authorize Mays Dermatology & Cosmetic Center to treat me or my dependent. All minors seeking medical treatment must be accompanied by a parent/legal guardian during the first office visit. After the initial appointment, a minor may be seen for treatment only with written and signed authorization from the parent/guardian which must be presented by the time of the appointment. This authorization will be valid for sevens year from the date it was signed. If you choose to send your child as an unaccompanied minor to an appointment, you must agree to all of the following:

I authorize Mays Dermatology& Cosmetic Center to write new prescriptions as deemed necessary for treatment. I authorize Mays Dermatology& Cosmetic Center to refill medications as deemed necessary for treatment. I authorize Mays Dermatology& Cosmetic Center to treat a new diagnosis as deemed necessary. I authorize my minor child to give verbal consent for minor procedures such as freezing/injecting/topically treating warts, injecting cysts, lancing boils. I agree that, should my child need any other procedures, including biopsies or excisions, these will have to be rescheduled for a time when he or she may be accompanied by a parent, legal guardian, or other person authorized to give consent.
I have read, fully understand and agree with the above.

Print Patient Name : _____ DOB_____

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Signature of patient or responsible party **Date**