mays
DERMATOLOGY & COSMETIC CENTER

Patient Name: _____

DOB: ____ / ____ / _____

FINANCIAL POLICY

We strive to provide the utmost care in the region. As a courtesy, our office will file your medical claim with your insurance company on your behalf. Our office will make best efforts to assist in obtaining your benefits, but we cannot force your insurance company to pay for services we have provided to you. Payment is expected and required for all services rendered regardless of your insurance coverage. Patients are required to provide a government issued ID and an up-to -date insurance card every visit.

- Patient payment obligation: I understand that insurance coverage is a contract between myself and my insurance company and not a guarantee of payment. Claims may be denied due to "non eligibility", "non-covered service", or "pre auth/certification not obtained" amongst many reasons. I understand that regardless of coverage I am fully responsible for any balances not covered by my insurance company for ALL charges for services rendered to me or to my dependents at Mays Dermatology& Cosmetic Center. If required by my insurance, I remain responsible and agree to obtaining any referrals, pre-authorizations, and/or pre-certifications prior to any visits or services. I am responsible for payment of balances resulting from lack of such documents shall my insurance deny the claim(s).
- Copays/Deductible/Co-insurance: I understand that Mays Dermatology is required by contract with insurance companies to collect any co-payment, co-insurance, and any unmet deductible **upfront** on the day of service. The amount collected at time of service is an estimate based on benefit information available. Once my claim is processed, I may owe additional amounts for my patient portion which will be due immediately.
- No Coverage: If I do not have insurance, or unable to provide valid insurance, I agree to be treated as a cash pay patient and must pay for all services rendered at time of service. In this case, I will be responsible for filing any paperwork for the claim on my own account if I wish to do so.
- Procedures: I understand that **biopsies** and other surgical procedures will result in 2 charges: one for physician performing biopsy, the 2nd for the pathologist (an MD) for processing and examining the specimen. I understand that I will be billed separately by the pathologist rendering histopathological diagnosis. I understand that procedures such as liquid nitrogen, canthacur, I&D, injections, curettage, and/or excision may have a separate and additional charge **due at time of the procedure**. 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.
- **Cancellation or No Show: I understand a fee will be charged if my appointment is cancelled less than 24 hours prior to its time for any reason or if I do not show for my appointment**. All surgeries require a deposit to schedule and this deposit will serve as my cancellation/no show fee if my surgery is cancelled within seven calendar days or if I do not show up to my appointment.
- **Upfront fees:** Fees due upfront on the day of my appointment include but not limited to copay/coinsurance/deductible and cash/cosmetic services. If the amount due up-front is under-collected, I agree to provide payment by end of day or my card on file will be charged for balance.
- **Cosmetic & Cash/Self Pay/Rewards membership**: I understand full payment for all cosmetic procedures, products, and/or self-pay services are due at the time of service. Self-pay services are any elective services that I choose to receive for cosmetic purposes or medical services which are not billed with insurance. All product, cosmetic, and self-pay sales are also final sale (no returns/exchanges). Membership fees are non-refundable and subject to change at any time.
- **Nonpayment**: If we are unable to receive due payment for medical, cosmetic, or products provided to you for any reason including but not limited to failure to provide payment, card denial, dispute/chargeback of payments, or any other reason, your account will be sent to collections, locked, and subject to administrative fees, collection costs, and/or attorney fees involved in your account.

CREDIT CARD ON FILE

We are committed to a simple and convenient billing process. You will be required to provide a credit/debit card on file with our office. Your card will be stored in a secure, PCI compliant system with only the last four digits visible. Card on file will be used to pay the following if we are unable to collect directly from you: any outstanding account balances, no show or same day cancellation fees, statement balances due, due upfront fees for deductible/copay/coinsurance/cosmetics if not collected or under-collected on date of service. You are not obligated to use this card for payments at our office, however if we do not receive payment from you when due, we will attempt to contact you and run the card on file for the full amount owed. If your payment is declined, we will attempt to reach you again. If we are unable to contact you, your balance will be sent to collections and your account locked, and subject to collection, administrative, and attorney fees.

I have read, fully understand, and agree with the financial policy above. I give Mays Dermatology and Cosmetic Center permission to charge my credit card for any balance(s) on my account for services or products rendered to myself or my dependent. By signature below, I hereby guarantee payment in full to Mays Dermatology & Cosmetic Center for all charges for services rendered and charges exceeding third party payment.

Signature: X_____ **Date _____**

CONSENT FOR TREATMENT OF MINORS

I understand that I am legally required to be present for the first visit of my child or any minor under my care, under the age of 18. I hereby authorize Mays Dermatology & Cosmetic Center, and its staff to continue evaluation, diagnosis, and treatment of my child, dependent or foster child without my presence in the office after the first visit. I consent to in-office procedures for my dependent minors that include, but are not limited to, cryotherapy, cautery, biopsies, and injections which are deemed advisable by Dr. Mays. I understand that while this authorization shall remain in effect, effective immediately and indefinitely, I may revoke this authorization at any time and for any or no reason by submitting a written request to the office.

Below is a list of individuals who have permission to bring my child in for treatment:

1. _____
2. _____
3. _____
4. _____

_____ _____

Signature of Parent or Guardian **Date**

HIPAA & AUTHORIZATION FOR TREATMENT

I have read and understood the Notice of Privacy Practices. (full detailed version is found on website (www.maysderm.com) and consent to use and disclosure of protected health information about myself or my dependent(s) for the purpose of treatment, coverage, and payment from my 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 below. I understand this list can be revoked at any time with my written authorization. I authorize examination, diagnosis, and 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 authorize Mays Dermatology& Cosmetic Center to prescribe new or refilled medications as deemed necessary for treatment of my conditions. I allow Mays dermatology & Cosmetic center to file for insurance benefits to pay for the care that myself or my minor receives. I authorize Mays Dermatology & Cosmetic Center to release all necessary medical records to government agencies, insurance carriers, and others (including independent utilization review or organizations) that are financially liable for the services in order for preauthorize services, determine or challenge medical necessity, and to determine the extent and/or amount of liability.

By signature below, I acknowledge that I understand and agree with above.

Signature: X _____ Date _____