mays

DERMATOLOGY & COSMETIC CENTER

Patient Name: ____ **DOB:** ___/___/_______

FINANCIAL POLICY

All Patients are required to provide a government issued ID and an up-to-date insurance card every visit or rescheduled. Minor patients must be accompanied by a parent on first visit and must have minor consent on file for future visits if unaccompanied by parent.

- **Patient Payment Obligation**: I understand that insurance coverage is a contract between myself and my insurance company and not a guarantee of payment. Claims denied/unpaid for any reason including but not limited to "non eligibility/non-network", "non-covered service", "bundled service" or "pre auth/certification not obtained" are considered the patient/guardian responsibility. I agree to obtaining any referrals, pre-authorizations, and/or pre-certifications required by my insurance prior to my visit as required by my plan. I understand that claims may be delayed in payment by my insurance company for many reasons including denials, record review, or unwillingness of my insurance company to properly address my claim in a timely manner. I understand that any pending insurance balance >90 days is subject to a hold on my account until fully resolved. Any Insurance balances >180 days will automatically be transferred to patient/guardian responsibility and due in full. **I understand that regardless of my insurance benefits, I am fully responsible for any balances not covered by my insurance company or deemed my responsibility for services rendered to me or to my dependent(s) at Mays Dermatology & Cosmetic Center.**

- **Upfront fees:** I understand that I am responsible for any/all co-payment, co-insurance, unmet deductible, additional procedures, and/or self pay/cosmetic services rendered **upfront on the day of service**. 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 due balance.

- **Office visit:** I understand that every time I am seen by the provider/physician in the office, it is considered an office visit evaluation. Any additional procedures performed during the visit are subject to a separate billed fee. If my insurance denies coverage for the office visit for or considers my visit as a "bundle" with my procedure, I am still responsible for full payment of my office visits rendered by provider. If my insurance company continues to deny provider evaluations and procedures on the same day, I may be asked to schedule office visits separately from my procedures.
- **Procedures:** I understand that procedures in office may have a separate and additional charge. I will be responsible for charges for any procedures performed in office including but not limited to biopsy, excision, liquid nitrogen, cantharidin, I&D, injections, curettage, and/or any others.
- **Non-Coverage**: If I do not have insurance, or unable to provide valid insurance information, I agree to be treated as a cash pay patient and must pay for all services rendered at time of service. I will be responsible for filing any paperwork for the claim on my own account if I wish to do so.
- **Pathology**: I understand that biopsies and other surgical procedures will result in two 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. 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**. Monday appointments must be cancelled by proceeding Friday to avoid no show fee. 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 (7) calendar days or if I do not show up to my appointment.

- **Cosmetic & Self Pay Services**: I understand payment for all cosmetic procedures and all self-pay services are due in full at time of scheduling. Self-pay services are any elective service that I choose to receive for cosmetic purposes or medical services which are not billed or covered by insurance including Medicare. If I choose to receive such services, I agree to sign all required consents including ABN.

CREDIT CARD ON FILE

We are committed to a 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, due statement balances, due upfront fees for deductible/copay/coinsurance/cosmetics/self-pay 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 tocontact 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:** ____________________

Cosmetic Sales Policy:

Cosmetic Products: All products are medical/prescription grade, high quality and stored in regulated temperature and humidity facility. In some cases, products are compounded and made to order. For these reasons and to allow for quality control, returns of anyproducts are not allowed after purchase. Defective products can be sent back to manufacturer for timely replacement subject to manufacturer regulations.

Treatment Packages/ Pre-purchases: Packages and pre-purchased services offer treatments at a much-discounted rate for larger or earlier purchases. If a package or service is pre-purchased and cancelled with no treatments utilized, the treatment package/purchase shall be refunded, subject to a **15% cancellation fee of the entire package/service value OR the entire value can be applied to another service**. If a package/service is purchased and treatment(s) are utilized, and the purchaser wishes to cancel the remaining treatment(s) prior to full redemption of the package/service, **the purchaser shall be refunded subject to a 25% cancellation fee of the total remaining non-redeemed package/service value, OR the remaining non-redeemed value can be applied to another service**. Pre- purchases and/or treatment packages must be redeemed within one (1) calendar year of purchase date. **There are no exceptions tothis policy.**

I have read and fully understand the above cosmetic sales policy. I agree to abide by the above terms and conditions.

Signature: X____**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:** _____________________

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 further agree to serve as the main guarantor/responsible party for my dependent's account per financial policy regulations of the practice. 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. Iunderstand 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: X____**Date:** _____________________