

Eastside Dermatology & Skin Care Center
150 Taylor Station Road, Suite 250
Columbus, Ohio 43213
614.863.3222

Patient ID #: _____ (Office Use Only)

Office Financial Policy

Patients are required to pay for health care and/or cosmetic services at the time services are provided. Upon request, we will be happy to provide you with an estimate of the cost for specific services before your appointment. We accept cash, checks, MasterCard, Visa and Discover credit and debit cards.

It is your responsibility to bring your most current insurance card with you to every office visit. You will be asked to present the card upon arrival. If you have changed insurance since the previous visit, please obtain the expiration date of the old policy and the effective date for the new coverage prior to your appointment. If this information is not provided, you will be expected to pay in full at the time of service.

Insurance Policyholders: Co-payments must be paid in full at the time of service. If your copay is not paid within 24 hours after your appointment you will be charged and additional \$15.00 fee. If your managed care contract does not cover certain services (typically cosmetic services) or if you do not have an active, valid insurance card, payment is required at the time of service. Please check with your insurance plan to verify that we are a participating provider. If we are not contracted with your insurance company you are required to pay in full for services at the time of your visit. Upon request, we will provide you with the information you will need to file a claim with your insurance company.

Referrals: Some insurance companies require a referral to see a specialist for any reason. It is your responsibility to call your insurance company to determine if a referral is needed. If a referral is required you must have your primary care physician complete the referral **prior to** your visit. If a referral is not completed you have 2 options: sign a waiver agreeing to pay for services at the time of your appointment or reschedule your appointment allowing time for a referral to be completed.

Payment of account balance: Account balances not paid after 2 statements have been sent to the responsible party will be forwarded to our collection agency and an account collection fee of \$30.00 will be charged to the account. Patients whose accounts are sent to collection will be asked to find another physician. Returned check fee of \$25.00 per item per return is charged for all returned checks.

Appointments not changed or cancelled in advance: If you need to cancel or change an appointment please contact our office at least 24 hours before your scheduled appointment. If you miss your appointment and it was not cancelled or changed at least 24 hours in advance fees will be charged as follows: office visit - \$25.00, procedure - \$50.00, surgery or laser treatment - \$100.00 and Mohs Surgery - \$150.00. These charges are paid by the patient not insurance companies.

Copies of Medical Records: There is a charge to the patients leaving the practice for producing copies of medical records. For more information speak with the receptionist.

Product Purchase and Return: All products must be paid for when ordered. All products purchased from Eastside Dermatology & Skin Care Center may be returned for a full refund within 4 weeks of the date of purchase. After 4 weeks no products are eligible for return.

Signature on reverse side

Covered/Non-Covered Services: **Eastside Dermatology & Skin Care Center is not responsible for knowing your insurance policy and what services are eligible for coverage. You must contact your insurance company to determine what your policy will cover.**

Please understand the billing staff of Eastside Dermatology & Skin Care Center will file all claims for covered services with your insurance company if the treating physician is a contracted provider. By signing this form you are stating that you understand you are responsible for any balances that may be due to the physician as a result of:

- **co-insurance or co-payments**
- **annual deductible amounts**
- **non-covered services**
- **out-of-network charges**
- **terminated coverage**
- **exhausted benefits**
- **no insurance coverage**
- **failure to respond to insurance company correspondence or inquiries**
- **fees related to non-payment, missed appointments, returned checks & others**

Release of Information and Payment Authorization:

All Insurance Companies and Third Party Payers: I hereby authorize Eastside Dermatology & Skin Care Center and/or any of its representatives to submit a claim to my Insurance Carrier or its intermediaries for all services rendered by the physician(s) and authorize my insurance carrier or its intermediaries to issue payment directly to Eastside Dermatology & Skin Care Center and/or physician(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.

Medicare and Medicaid: I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of Medical or other information about me release to the Social Security Administration, Medicare, Medicaid, or its intermediaries or carriers, any and all information needed for this or a related Medicare or Medicaid claim. I authorize and request that payment be made directly to Eastside Dermatology & Skin Care Center.

Guarantee of Payment: I understand that filing claim with my insurance company or other third party payer, under any circumstances, does not relieve me from my responsibility for the payment of all charges, I further acknowledge that I am responsible for the payment of all charges for services rendered by Eastside Dermatology & Skin Care Center to me or the patient indicated. By signing this document I personally guarantee the payment of these charges for medical services rendered. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I understand that I will receive a statement for any balance due after the claim has been processed by the insurance company. I understand and agree that the balance on my statement will be paid in full to the physician within 30 days. If the balance is not paid within 30 days, I understand my account will be subject to the collection process, including the collection fee, and that I may be turned away for non-emergent services until the balance is paid.

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

Print name of signature: _____