DERMATOLOGY

ASSOCIATES OF ITHACA

Billing Policies

Welcome to Dermatology Associates of Ithaca. We are dedicated to providing the best possible care and service to you and regard your understanding of our billing policies as an element of your care and treatment. Please let us know if you have any questions or concerns. At every visit, we will ask you to present your up-to-date insurance card, as well as to verify your current address and phone number to ensure that we have your correct information on file.

Referrals and Preauthorizations: If your insurance plan requires that you have a referral or preauthorization to see a specialist, we must have that before you will be seen. Referrals are obtained through your primary care physician, and preauthorizations are obtained from your insurance company. If your insurance company does not pay your bill due to a referral or preauthorization dispute, you will ultimately be responsible for payment.

Courtesy Billing: As a courtesy to you, we will bill your insurance regardless of our participation status. If we do not participate with your insurance, you are responsible for all charges and will be billed accordingly. Please refer to your insurance company for confirmation of participation status and coverage of benefits.

Co-Pays: Payments are due at the time of service. There is a $25 fee if we have to send your unpaid bill to collections (see Unpaid Personal Balances below).

No-Show Fees: If you are unable to keep your appointment we require at least one business day's notice Office appointments not cancelled or rescheduled with one business day's notice are subject to a $30 no-show fee, which is not covered by insurance. Surgery no-shows are subject to a $50 no-show fee. No-show fees must be paid before your next visit. Repeated no-shows may prevent you from being able to schedule future appointments until the fees are paid. We understand that extenuating circumstances may prevent you from calling beforehand. If that is the case, please call us as soon as you are able to do so. We are happy to discuss it with you.

Returned Check Fee: You will be subject to a returned check fee of $20 if a check is returned from your bank.

Unpaid Personal Balances: Any unpaid personal balance over 90 days (either self-pay, co-pays, or balances after insurance) is subject to 1.5% per month interest. If you need to make payment arrangements for personal balances, we are happy to consider this; however, the request must be made in writing to our billing department to avoid the interest charge.

Self-Pay Patients: Dermatology Associates of Ithaca offers a 50% prompt pay discount to uninsured patients/guarantors. (For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.) Payment is due at the time of service unless other arrangements are made with our billing department. We will request your written signature validating you have no other medical coverage.

During the course of your visit the provider may perform certain procedures that result in additional charges, such as but not limited to: skin biopsies, skin surgeries, and liquid nitrogen treatment. These charges may be subject to co-pays and/or deductibles by your insurance company. If a biopsy is performed, then you may be subject to a charge from the pathology laboratory. By signing this you agree to all terms and conditions, and are responsible for any and all outstanding balances incurred by these services.

Thank you for choosing Dermatology Associates of Ithaca.

I authorize Dermatology Associates of Ithaca to bill my insurance and to release any information to my insurance that is necessary to settle a claim on my behalf for services rendered while a patient of Dermatology Associates of Ithaca. I also authorize payment to be made directly to Dermatology Associates of Ithaca.

If my insurance denies payment for certain services I agree to be personally and fully responsible for payment.

x_____ _____

Patient Signature Date

□ **Uninsured Patient:** I hereby attest that I am not insured.

x_____ _____

Patient Signature