Agreement of Financial Responsibility

Thank you for choosing PS DERMATOLOGY AND SURGERY/PS FOOT AND ANKLE as your healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- A photo ID is required for all patient visits. We will ask to make a copy of your ID and insurance card for our records. Proof of insurance is required for all patients that are not paying cash time of service. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

- We require all patients to pay their copay at the time of service. This arrangement is part of your contract with your insurance company. We accept cash, check, and credit cards. If a check is returned for any reason, you will be charged a $35 fee in addition to the amount of your check.

- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, whether your insurance requires a referral (sometimes, but not always, written on your insurance card), your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. Please contact your insurance company with any questions about your benefits and coverage.

- We will attempt to confirm your insurance coverage prior to your treatment, however this is not a guarantee of coverage as that is between you and your insurance company. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage.

- We participate in most insurance plans. If we have a contract with your insurance company, we will bill your insurance company first, and then bill you for any amount determined to be your responsibility, less what was collected at the time of service (copay amount).

- If we do not contract with your insurance company, we will, as a courtesy, file a claim with your insurance carrier. Please understand some insurance coverages have out-of-network benefits that may be subject to deductibles and higher out of pocket responsibility from you. If you receive services that are part of an out-of-network benefit, your portion of financial responsibility may be higher than if you used an in-network provider. Once your insurance processes the claim, we will send you a statement for your balance due. Payment is due upon receipt of the statement.

- Please be aware that some - and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. We will provide you

with an estimate of these costs should the issue present itself. We collect payment based on this estimate at the time of visit.

- Recent changes in healthcare markets have altered insurance coverages for many of our patients. Many policies have higher deductibles which means, even if a procedure is covered by insurance, you may still receive a bill as that is how you and your insurance company have decided your plan is setup. These external factors make it necessary for our office to maintain a credit card on file for all commercially insured patients. Your card information is stored with security that is HIPAA compliant in nature. Should you have a balance after your visit, we will send you an invoice via email. If no payment is received after fourteen (14) calendar days, we will bill your card on file. By signing this form, you authorize our office to bill your card on file. Receipt of any transaction will be sent via email to your email on file. Upon request, invoices and transactions can sent by mail as well.

- Patients with an outstanding balance must make payment arrangements prior to scheduling future appointments. Chronic nonpayment may result in referral of balance to an outside collection agency and termination of physician services - please help us to avoid this.

I have read the policies contained above, and my signature at the end of this combined document serves as acknowledgement of a clear understanding of these policies. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay such charges in full.

_____Printed Name (Patient/Parent or Legal Guardian)
_____ Signature (Patient/Parent or Legal Guardian)
_____ Relationship to Patient (if applicable)
_____ Date