WASATCH DERMATOLOGY
Compassion. Tradition. Excellence.

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us as your health care provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future medical evaluation or treatment in this office. All patients must also complete the information and insurance form before seeing a provider. The content of this document may not be changed.

1. ***Patient Information/Proof of Insurance:*** At each visit, all patients must complete/verify patient information before seeing the provider. We must obtain a copy of your driver's license or legal identification and current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for payment of services rendered.
2. ***Non-Insured:*** Patients who have no insurance are required to pay 100% of services rendered at each visit. If this is not possible, you will need to make payment arrangements with our billing office prior to any medical evaluation or treatment. We accept cash, checks and major credit cards.
3. ***Insurance:*** We participate in most insurance plans, including Medicare. If you are not insured by a plan with which we are contracted, payment in full is expected at each visit. If we are a participating provider with your plan, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits and rules is your responsibility. Please contact your insurance plan with any questions you may have regarding your coverage.
4. ***Referrals:*** Your insurance may require a referral form from your primary care physician for procedure/service(s) prior to your visit. It is the patient's or guarantor's responsibility to obtain the appropriate referrals prior to your office visit. If you are unable to produce a referral at the time of your visit, you will be given the option to reschedule the visit or sign a waiver of insurance and pay for the visit in full.
5. ***Co-payments and Deductibles:*** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, deductibles and co-insurance from patients can be considered fraud. Deductibles are due at the time of notification by your insurance company. Such notification may be a verbal notice at the time of insurance verification, an Explanation of Benefits from your insurance company or a statement from Wasatch Dermatology.
6. ***Non-Covered Services:*** Our providers follow appropriate medical guidelines for standard of care based on your medical condition. Please be aware that some of the services you receive may be determined to be non-covered or not considered reasonable or necessary based on the benefits of your specific plan. You will be financially responsible for the cost of services that are not paid.
7. ***Coverage & Changes:*** You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay. If your insurance company has not paid your full account within 60 days, you must pay the outstanding balance without further delay. If your insurance changes, please notify us before your next visit to help you receive your maximum benefits. Failure to notify us of insurance changes could result in denial of claims and patient responsibility for payment of the denied claim.
8. ***Claims Submission:*** Your insurance benefit is a contract between you and your insurance company. We will submit your claims for the services which have been provided. Your insurance company may need you to supply certain information directly in order to process a claim. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.
9. ***Non-Payment/Delinquent Accounts:*** *Each patient is responsible for his or her own bill*. If the patient responsibility portion of your account is over 30 days past due, and you have not made payment arrangements, you will receive a notification stating that you have 45 days for commercial insurance or 60 days for Medicare insurance to pay your account in full to halt collection activity. In the event any amount is referred to a third party debt collection agency, I agree to pay any other amounts allowed by law, such as interest, court costs, reasonable attorney's fees, postage, etc., I will also be responsible for a collection fee of up to 33.3% of the principal amount owing as allowed by the Utah Code. The terms of this paragraph shall apply to all amount(s) incurred by me or any individual for whom I have legal responsibility, whether such amount(s) are incurred today or after today.

10. ***Finance Charges:*** Payment in full is required on all outstanding balances unless payment arrangements are made in advance with our billing department. A monthly finance charge of 1.50% per month (18% annual rate) will be charged to the amount not paid after 60 days.
11. ***Late Arrivals:*** A patient who arrives more than 15 minutes after his/her appointment is considered a late arrival. A late arrival, not considered to be the responsibility of the Practice, will be registered and worked into the schedule as soon as possible. If the patient is more than 30 minutes late, the appointment may be rescheduled.
12. **Refunds:** In the event that you have overpaid on your account, a refund check will be mailed to the patient or guarantor.
13. **NSF Fee:** A $25.00 fee will be charged on all returned checks.
14. Patients will be held liable for any damage done to the office.

USUAL AND CUSTOMARY RATES

Our rates for medical services reflect the usual and customary rates in the community. Unless we have accepted an alternate fee schedule from your insurance, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for medical services.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers, pharmacy including formulary and prescription history, and to requesting referring providers (if any).

AUTHORIZATION TO PAY BENEFITS

I further authorize and direct said agency, attorney or Insurance Company to pay from the proceeds of benefits of any recovery of insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I understand that there are several types of advance directives; the two most common forms are living wills and a durable power of attorney designation. I understand that in the ambulatory care setting, if I suffer a cardiac or respiratory arrest or other life-threatening situation, signing this document grants consent for resuscitation and transfer to a higher level of care. Therefore in accordance with Federal law, Wasatch Dermatology Center is notifying you that it will NOT HONOR previously signed advanced directives. If this is not acceptable to you, you must address this issue with your physician prior to performing the procedure.

I certify that I have read this document, and am the patient, or am duly authorized to execute it and accept its terms.

PRINT NAME	***SIGNATURE***	***DOB***	***DATE***

HIPAA PRIVACY NOTICE: I acknowledge that I have received Wasatch Dermatology's HIPAA PRIVACY notice and have had the opportunity to review its content. _____ **(please initial)**