Patient Consent to Treatment & Financial Responsibility

I. Consent for treatment: I authorize Desert Dermatology PLLC and/or Michelle Goedken DO to examine and render treatment to me/my dependents for dermatological and medical/surgical care.

II. Assignment of Benefits/Release of medical information and Financial Responsibility: I hereby authorize payment by an insurer directly to Desert Dermatology PLLC for all benefits payable under the terms of the insurance policy during the period of the services rendered. Your fees are only for services performed at or by our practice. There may be other fees associated with pathology, lab work or other related medical care not affiliated with our office, you may receive separate billing from these outside facilities. This office has contracts with Medicare and with many managed care plans. Please check with our reception staff to determine whether your plan is one of these. However, it is ultimately the responsibility of the patient/guarantor to determine if Desert Dermatology PLLC is a participating provider. If we have a contract with your plan, we will file a claim with your insurance company. When we bill your insurance company, any deductible and co-insurance charges will apply. Any payment that you make on your visit will be credited to your account. Once the insurance company makes payment, you will be responsible for all remaining balances. Please note that ANY procedure performed in our office may be applied to a surgical deductible or co-insurance. Surgery is considered anything that breaks skin – this includes injections/destruction of lesions and biopsies. If arbitrary determination of a participating insurance company determines that services are cosmetic or not medically necessary, the patient/guarantor will be responsible for the outstanding balance.

*A healthcare deductible is the amount that you must first pay before your insurance will make any payment. Once you have met the full amount of your deductible, your insurance company will then make payment on future visits to any healthcare provider. The deductible must be paid every year, usually beginning January 1st.

**Once your deductible is met, many insurance companies still do not pay 100% of the healthcare cost. If that is the case you will have a copay or co-insurance, which is a partial payment required by you in addition to what the insurance company will pay. It can be from 10-50% of the allowed amount until you have accumulated enough medical bills to meet your yearly out-of-pocket maximum.

*******This is an <u>estimated</u> portion that is due. Unfortunately, we don't know exactly what your insurance will cover or what you will be billed until your claim is processed.

If you do not have one of the plans with which the practice is contracted, the total cost of your visit is required at the time of service. We can provide an estimate as required by the No Surprise Act.

If at any time you are concerned about the cost of a procedure proposed by the doctor, you may ask for someone from the billing office who will be happy to discuss the cost with you. Payment in full is expected on outstanding balances.

In the course of outstanding balances, two statements will be generated, after which, a notice prior to collections will be mailed. If a payment plan is necessary, terms and conditions will be determined solely by Desert Dermatology PLLC, not by the patient/guarantor. There will be a 50% charge added to the outstanding balance due plus required postage if the debt is referred to a collection agency for collection. If legal action is necessary, the associated fees assigned will be added to the fees incurred from medical treatment. Printing of any records for legal, life insurance, personal or other reasons will be charged based on number of copies to cover labor and supplies.

III. Digital Photography: I authorize the physicians/staff of Desert Dermatology take digital photographs that relate to my care. Desert Dermatology PLLC will only disclose information relevant to my care to permitted persons and all physicians who care for me. The photographs may be used for teaching, academic and research purposes so long as my identity is concealed.

IV. Referrals/Authorization: I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. Payment in full is required at the time of service.

V. Appointment No- Show, Change and Cancellation Policy: Our office does not over schedule clinic and therefore will need 24 hrs notice to change or cancel an appointment. Patients arriving more than 20 minutes after appointment start time may not be admitted to the clinic and considered no- show. This policy allows our office to function with efficiency and provide the best care to all our patients

*Missed Clinical Appointment - $45

**Missed Cosmetic Appointment - $100

***Missed Surgical Appointment - $200

I have reviewed the statements above and understand my responsibilities and if I don't understand my responsibilities, I agree that I can ask questions!

Patient or Responsible Party
Signature_____Date_____

CREDIT CARD AUTHORIZATION

Desert Dermatology has implemented a credit card policy. Recent Changes in healthcare market and payment process have altered insurance coverage to shift more cost of care to our patients. The credit card on file policy is a convenient method to pay for the portion of services that are deemed patient's responsibility, such as copay, deductible, and co- insurances.

You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card. This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. Co-pays due at the time of the visit will, of course, still be due at the time of the visit. If you have any questions about this payment method, do not hesitate to ask. I authorize Desert Dermatology PLLC, its doctors, and/or staff to issue charges to my credit card account (shown below) under the following circumstances: INITIALS

_____ I understand that I am responsible for payment of the following charges at the time of service: deductibles, services not covered by my insurance policy, medically unnecessary/cosmetic services, co-payments, and insurance balances from previous appointments (should my primary insurance be with a company with which Desert Dermatology PLLC is contracted).

_____If my insurance company is not one with which Desert Dermatology PLLC is contracted, I am responsible for the entire amount of charges at the time of service. I acknowledge that a representative of Desert Dermatology PLLC billing department is available to explain the charges to me and I agree with this amount.

_____ If, after my insurance pays on my claims and a patient balance becomes due to Desert Dermatology PLLC , I authorize this office to generate charges to my major credit card account for that unpaid balance without further permission or notice.

I authorize Desert Dermatology PLLC to keep my debit /credit card on file and to charge my debit/credit card for any outstanding balances that my health plan has identified as my financial responsibility. If the provided debit/credit card has changed, expired, or denies for any reason, I agree to immediately give Desert Dermatology a new, valid debit /credit card which I will allow to be charged over the phone. I agree that the new card can be saved and used with the same authorization as the original card I presented.

☐ **Visa**	☐ **MasterCard**	☐ **Discover**	☐ **American Express**
Patient's Name (print):			
Date of Birth (mm/dd/yyyy):			
Cardholder Name (print):			
Last Four Digits of Debit/Credit Card Number:			Exp. Date:
Card Billing Address:			
☐ Please check this box if you prefer not to receive a statement and would like us to bill your debit/credit card immediately for any balances due after the processing of your insurance.			

Debit/Credit Card Holder's Signature:_____Date: _____

Authorization Received by:_____(Initials) Date: _