Medical Services Financial Agreement

Denver Skin Clinic, PC ~ 2200 East 18th Ave. Denver, CO 80206

Insurance

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal we need your assistance and your understanding of our payment policy.

You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card. We are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements.

We will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days.** It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements, and to be sure all insurance information is current. If you give the wrong insurance information and a referral is required, you will be responsible for the charges. We will, however, assist you to ensure that all plan requirements are met.

_____ please initial

On occasion, a biopsy done by one of the physicians at Denver Skin Clinic may be submitted for a second opinion to University of Colorado Dermatopathology Consultants (UCDC). Should this become necessary, your insurance company will be billed by University Physicians for this service.

_____ please initial

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.

_____ please initial

Payment for Services

Payment for services, including insurance co-payment or self-pay balance amount, is due at the time services are rendered unless payment arrangements have been approved in advance by the Office Manager. We accept exact cash, checks, MasterCard, Visa and Discover. Our failure to collect these amounts may be a violation of our contract with your insurance company. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to your employer and/or insurance company representative.

_____ please initial

Please complete all lines on the Reverse side >>>>>>>>

Returned checks will result in a $25 fee that will be posted to your account. Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees.

_____ please initial

General

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Cancelled Appointments

Charges may be incurred for broken, confirmed appointments and appointments cancelled without 24 hours notice. Your cooperation in canceling your scheduled appointment well in advance allows us the opportunity to offer your appointment to a person who needs medical care. **Failure to show for a scheduled, confirmed appointment may result in a $25 cancellation fee.**

_____ please initial

If you have any questions about the above information, please do not hesitate to ask us.

Thank you,

My signature below constitutes acknowledgement and acceptance of this policy.

Patient name – Printed:_____

Patient or guardian signature: _____

Date: _____