FINANCIAL POLICY & OFFICE PROCEDURES

Dear Patient:

We appreciate your confidence in choosing Premier Dermatology, PLLC for your skin care needs. Please take a moment to review our financial policy so that you understand your responsibility regarding the charges for the services rendered to you by this office. We require you to read and sign our electronic version of this document prior to receiving treatment.

When asked, and as a courtesy to you, we will try to give you general guidelines about what your insurance policy might cover. Since medical insurance is an agreement entered into by you and your insurance carrier, you are ultimately responsible for knowing the specifics of what your policy covers and for notifying us when your insurance changes. Failure to update us with changes in your insurance coverage may result in a denial of coverage from your carrier, and in that case, you would be responsible for payment of the entire amount due. Payment is due at the time of service. Acceptable forms of payment are cash, check, VISA, MasterCard, Discover, and American Express.

IN-NETWORK: For those patients covered by insurance plans with which we are participating providers, we will determine your copay due at the time of the visit. Co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are due at the time of service. We will file the insurance claim to the insurance company.

OUT OF NETWORK: In the event that your insurance coverage changes to a plan with which we are not participating providers, we will require payment in full at the time of service and we will file your claim to the insurance company as a courtesy. Any charges that are not paid by your insurance company are your responsibility.

SELF-PAY: Self-pay or uninsured patients are responsible for payment at the time of service.

If we participate (i.e. are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for the charges that relate to COVERED

services rendered. This means that services for the removal of benign lesions, which are not likely covered by insurances (for example: skin tags, seborrheic keratoses, telangiectasia, and other COSMETIC procedures), will be paid at the time of service. We will bill both your primary and secondary insurance plans for covered services under the contracted plans. Complete insurance information, including referrals from other providers, for primary and secondary insurance coverage(s) must be made available to the Practice including all identification, benefits cards/documents, and any other information required by your insurance carrier, for accurate filling of claims. In the event that we are not aware of a charge that is not covered by your plan, you will be billed the balance after we obtain the denial from your insurance. You are responsible at the time of service for payment of: co-payments, and/or charges for non-covered or cosmetic services.

ABOUT CO-PAYMENTS: If you are an enrollee of a managed care plan (HMO or PPO) that we are contracted with, you are required to pay the co-payment each time you are seen, (including follow-up appointments) and it must be paid before you see the physician. If you are not prepared to pay the co-payment, the visit must be rescheduled. If you do not know your co-payment, we will collect $30 for your co-payment at check-in.

ABOUT REFERRALS: If you are enrolled in an HMO or other plan which requires a referral from your primary care physician, you must have the referral with you OR the referral must have been sent to us in advance of your visit in order to be seen by the physician. You are responsible for obtaining you own referral (from your primary care physician), FOR EVERY VISIT.

MEDICARE PATIENTS: We are a Medicare participating provider. We will bill Medicare. You will be responsible at the time of service for co-payments and charges for non-covered or cosmetic services. If you have Medicare as well as a secondary coverage with a commercial plan or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill, and you will be responsible for the balance.

FOR NON-MEDICARE PATIENTS: If you have insurance coverage with an insurance carrier which we have no contractual relationship, please note the following: you are responsible, at the time of service, for payment of all services. You will receive forms at the time of service which you can use to bill your primary and secondary insurance plans for any reimbursement that may be due from you

under your policy. Please understand that if we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits.

CANCELLATION POLICY: We recognize that everyone's time is valuable, so we make every effort to maintain the scheduled appointment times. If you arrive more than 10 minutes late for your scheduled appointment, you may be asked to reschedule.

YOUR APPOINTMENT TIME IS RESERVED EXCLUSIVELY FOR YOU. WE REQUEST THAT YOU ALLOW ONE HOUR TO BE IN OUR OFFICE. WE WILL CHARGE $75 ($125 FOR SURGERY) FOR EVERY MISSED APPOINTMENT/ APPOINTMENT CANCELED WITHOUT 24 HOURS ADVANCE NOTICE.

COSMETIC CANCELLATION POLICY: Should you need to cancel or change the date of your cosmetic procedure; we require at least 24 HOURS NOTICE as a courtesy to other patients seeking our services. Any cosmetic procedure canceled without 24 hours' notice will incur a $125 CANCELLATION FEE.

RX REFILLS: Please contact your pharmacy for any refill requests. They will electronically contact the office for approval. Allow up to 48 business hours for refills to be completed. Refills received after 3:00 PM on Friday will be considered part of Monday's business.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits to Premier Dermatology, PLLC on my behalf for any services and materials furnished. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents for information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above

medical information to the insurer of agency shown, and authorizes my doctor to act as my agent, as above.

FINANCIAL ACKNOWLEDGEMENTS: I understand that regardless of any insurance coverage or other potential co-guarantor or responsible party I am accepting full financial responsibility for payment of all charges for services provide to me, my spouse or dependents by this practice. I agree that if my employer, insurance carrier or plan sponsor denies payment to all of or any portion of my claim, I will be financially responsible for all outstanding charges. I agree to pay a minimum monthly billing charge of $5.00 or interest at the rate of 1.75% per month (whichever is greater) on any balance not paid within 30 days of the date of service. In addition, should my account become delinquent and assigned to a collection agency, I agree to pay an additional collection charge of 33% of the outstanding balance or a minimum of $40.00 whichever is greater to offset in part the collection agencies fee charged to this practice. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 50% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee.

TCPA ACKNOWLEDMENT: I authorize this office, its agents and assignees to contact me by telephone, text, SMS, and/or via an automated dialing system with live or recorded voice in connection with any of my accounts with this office and at any telephone number I have provided as of this date or in the future.

Date:_____

Print Name:_____

Signature:_____