Patient Financial Agreement

PLEASE READ THOROUGHLY AND SIGN BELOW.

In consideration of receiving services from a Seaside Dermatology facility, you agree:

1. All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. KNOW YOUR BENEFITS.
2. On the date of service, we will collect your deductible, co-pay, and payment for any uncovered services as well as the patient's portion as determined by insurance.
3. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. It is your responsibility to notify this office immediately if your insurance coverage or company changes. 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.
4. We will bill your insurance company as a courtesy but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond we will follow up with an inquiry on your behalf. If, however, your insurance does not respond again, a statement will be sent to you. You should call your insurance to question why the claim is not paid. Our office will be happy to assist after you have contacted your insurance.
5. If your medical claim has not processed and your insurance company has not resolved your dispute, you may register a complaint with the South Carolina Department of Insurance. Our office will do everything we can to assist you, however you must understand you cannot delay payment while you are awaiting the outcome of your complaint.
6. Any unpaid charges over 90 days old will be considered for an outside collection agency. You are responsible for any collection fees, legal fees, or court costs incurred in the collections process. This agency will report your failure to pay to the THREE (3) national credit reporting agencies.
7. Non-Insured: If you do not have medical insurance, you will be responsible for payment at the time of service for the service to be received that day, as well as any previous outstanding balance. If a procedure is necessary, payment may be required prior to the procedure.
8. Seaside Dermatology caps patient balances at $250. While we expect all accounts to be current, we do realize the financial hardships that medical bills can carry. A patient will be not be seen with a balance over $250. Should you need to be seen at our facility, your will be required to pay your balance down to at least $250 before a visit takes place.
9. You will be assessed a $20 service fee on all returned checks due to insufficient funds in addition to the amount of the actual check. If your account becomes delinquent, the guarantor is responsible for any collection fees, interest, or attorney fees.
10. Non-Covered Services: Some services we provide may be deemed not medically necessary by your insurance carrier or not a covered benefit by your specific policy, therefore not paid by your insurance. Many cosmetic procedures we provide are not covered by insurance. The patient is responsible for payment at the time of service for all services not covered by insurance.
11. Laboratories: If your insurance company requires a specific laboratory, it is your responsibility to notify us. Otherwise, we will send your specimen to a cooperating laboratory. If there are any costs related to the biopsy, pathology, cultures, or other lab work that your insurance carrier does not cover you will be responsible for those costs.
12. If you are enrolled in a Managed Care Insurance Plan (HMO) it is YOUR responsibility to obtain or ensure that a referral and/or authorization is supplied to our office from your primary care physician prior to the time of your appointment. We commonly schedule routine follow up exams as a courtesy to you upon checking out. Unfortunately, these future appointments may be outside of authorization extension allowance and require new authorization that our office is unable to complete on your behalf.
13. We are committed to providing you with the best possible care, and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

PATIENT/GAURDIAN SIGNATURE DATE

PATIENT/GAURDIAN Printed Name

HIPAA: Private Information Release Authorization

I, _____, hereby authorize Seaside Dermatology, P.A. to discuss with the following people information concerning my health treatment, billing, insurance information, and appointments.

☐ Spouse Name: _____

☐ Parent / Legal Guardian: Name: _____

☐ Significant Other Name: _____

☐ Any Specified Person Name: _____

Restrictions:

☐ No Restrictions

☐ Do not discuss any information regarding my health including appointment time, test/lab/pathology results, pre and post surgery instructions, billing/insurance, or account information with anyone except me.

☐ Only discuss my appointment time with the above named individual(s).

☐ Only discuss my test/lab/pathology results with the above named individual(s).

☐ Only discuss my pre and/or post surgery instructions with the above named individual(s).

☐ Only discuss issues concerning my account, including insurance, and/or billing with the above named individual(s).

MESSAGES MAY BE LEFT ON MY ANSWERING MACHINE REGARDING THE ABOVE

☐ Yes

☐ No

I understand I may terminate this consent at any time by giving written notice to Seaside Dermatology, P.A.. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____

Printed : _____