



CENTER FOR DERMATOLOGY  
AND SKIN SURGERY, INC.

## Financial Policy

This agreement is between Center for Dermatology and Skin Surgery, Inc., a Florida corporation, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Center For Dermatology and Skin Surgery, Inc.

By executing this agreement you are agreeing to pay for all services that are rendered.

**Monthly Statement:** If you have a balance on your account you will receive a monthly statement. Your statement will show the balance due us and any finance charges that may apply.

**Payments:** Unless other arrangements are made in advance, and in writing, the balance on your statement is due and payable upon receipt, and becomes past due if not paid by the end of the month. In order to provide you with the highest quality service we offer paperless billing. We simply maintain your credit, debit, or check card number on file to satisfy all co-payments, deductibles, and balances for non-covered services as determined by your insurance company.

**Charges to Account:** We reserve the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

**Telephone Consults:** At the physicians' discretion a fee may be charged based upon the complexity of the issue. This fee must be paid before future services are rendered.

**Finance Charges:** A finance charge will be imposed on all patient balances remaining unpaid after 30 days. The **FINANCE CHARGE** will be computed at the rate of one and one half per cent (1.5%) per month or an **ANNUAL PERCENTAGE RATE** of 18%. The finance charge applies to the "past due" balance of your account. There will be a minimum finance charge of \$.50 on all past due balances.

**Insurance:** Your health insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company only if we are a contracted provider of that insurance company. Although we may estimate what your insurance company may pay, it is the insurance company that determines your eligibility for services rendered. You agree to pay any portion of our charges not covered by your insurance company.

**HMO Plans:** All co-payments due under your insurance plan must be paid at the time of service.

**PPO Plans:** We have agreed to accept the discounted fee from your plan, however, all co-insurance is your responsibility. We will estimate balances due us to the best of our ability. Since this is only an estimate we recommend that you maintain a paperless account with us. After your insurance company has paid us we will charge your credit, debit, or check card. You would also have the option of paying by check. Please indicate which option you prefer.

\_\_\_\_\_ Transfer my balance to my card.

\_\_\_\_\_ Call first, I might want to pay by check.

**Missed Appointment Fee:** When you do not show up for an appointment, or cancel an appointment with less than 24 hours notice, a fee of \$35 will be charged. This fee must be paid before we schedule a new appointment. If you miss three scheduled appointments you will be asked to transfer your records to another doctor. **You may call us in advance to cancel your appointment at (813) 977-3600. If after hours, please dial zero and leave your message with our answering service.**

**Checks Returned Unpaid by your Financial Institution:** You will be charged a \$30 special handling fee if your check is returned to us unpaid. We will notify you of the returned check and the amount owed to us including the \$30 special handling fee. You will be asked to pay the amount due at our offices within 5 days of our contact with you. You may pay the amount due with cash, credit card, debit card, or money order. If there are two episodes of dishonored checks we will not accept a check for future services.

**Co-Signature:** If this or another Financial Policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation of co-signature is received it will apply only to future charges to your account.

**Divorce Decrees:** We are NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. If you accompany your minor child you will be responsible for the bill at the time of service.

**Cosmetic Procedures not Covered by Insurances:** If you set an appointment for a cosmetic procedure you will be required to pay a \$50 non-refundable appointment deposit at the time you make the appointment. At the time of your appointment the \$50 deposit will be applied to charges for services performed. If you miss your scheduled appointment time you will forfeit your \$50 deposit. However, if you cancel and reschedule your appointment no less than 24 hours prior to your scheduled appointment your deposit will be carried over to the next appointment.

**Finance Charges:** A finance charge will be imposed on all patient balances remaining unpaid after 30 days. The **FINANCE CHARGE** will be computed at the rate of one and one half per cent (1.5%) per month or an **ANNUAL PERCENTAGE RATE** of 18%. The finance charge applies to the "past due" balance of your account. There will be a minimum finance charge of \$.50 on all past due balances.

**Past Due Accounts:** If your account becomes past due we will take all necessary steps to collect this debt. If we have to refer your account to a collection agency or attorney you agree to pay all costs of collections, including agency fees, reasonable attorney fees, and filing and court costs. In the event of a lawsuit, venue shall be in Hillsborough County, Florida.

**Waiver of Confidentiality:** You understand that if your account is submitted to an attorney or collection agency, or we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**Transferring of Records:** If you request copies of your medical records for any reason, including transferring to another doctor, you must do so in writing, and pay us a reasonable service fee as allowed by Florida State Statute. Our current fee is \$1.00 per page for the first 25 pages and \$.25 per page thereafter. This fee also applies to requests to fax your medical records. You authorize us to include all relevant information as requested. If you request another doctor or organization to transfer your medical records to us, you authorize us to receive all relevant information.

**Personal Injury:** If you are being treated as part of a personal injury lawsuit or claim, we require that you allow us to bill your health insurance company. Payment of our fees remains your responsibility. We cannot bill your attorney for charges incurred due to personal injury.

**Financial Hardship:** We are required by Medicare and/or your health insurance plan to collect from you all deductibles, co-payments, and co-insurances. We cannot waive any of these amounts. However, we do recognize that there may be extenuating circumstances that render you incapable of making these payments timely or at all. It is our policy to examine each such occurrence on a case-by-case basis to determine whether special consideration will be given.

<b>Patient's Name:</b> _____	
<b>Responsible Party</b> (if not the Patient) _____	
<b>Signature:</b> _____	<b>Date:</b> _____
<b>Co-Signature (if required):</b> _____	<b>Date:</b> _____