At Dermatology San Antonio, we believe that all patients who are rendered care at this office deserve the best medical care that can be provided. We provide you with the Agreement regarding our financial policy and your agreement to pay for services provided so that you are aware of our policies and procedures up front. We require each patient to sign and date this Agreement on the last page to indicate you accept these terms.

PAYMENT AT TIME OF SERVICE, FEES AND COLLECTIONS

We require that you pay any amount not covered by your insurance under your policy on the date of service. Dermatology San Antonio is required, in accordance with its contract with your insurer, to collect deductibles and copayments at the time of service. We will determine your copay and how much of your yearly deductible under your policy has been met for the year, if possible. If you are unable to pay your copayment at check-in, another appointment will be made for you. Account balances must have a monthly payment plan in place and any monthly payment not received by the date of your scheduled appointment will be required to be paid prior to seeing a provider. We will always work with you to arrange a payment plan.

We will request to see your current insurance card and photo identification so that we may verify insurance accurately. If a claim is rejected because your insurance does not cover the type of service rendered or if you provided us an expired insurance card, you will be held financially responsible for payment of services and any outstanding balance.

CREDIT CARD ON FILE

We require a credit or debit card on file with our office. We need to ensure that we have a guaranteed form of payment on file in our office.

We do not store your sensitive credit card information in our office. We store it in a secure fashion with a reputable financial firm called a Gateway which is handled by our merchant services vendor. We access your information only on this site to process a payment. You will be required to sign a credit card on file authorization statement that will allow us to charge an amount agreeable to each of us until your balance is paid in full.

We will always work with you to understand if there has been a mistake, and we will refund you if we have made a billing error. We will only charge the amount that we are instructed to by your insurance carrier.

Once we determine your personal financial obligation or after your insurance company pays Dermatology San Antonio for a portion of your care, we will begin to process payments that were previously discussed and approved by you.

Any account past due by 30 days or more may be subject to submission to our collection agency. Dermatology San Antonio reserves the right to discharge, with proper notice, any patient for non-payment. By signing our financial policy, you agree to pay these added fees, along with any and all costs associated with the collection of your account.

If you carry a balance on your account during the time you present at our office, a payment on your account will be required at the time of service unless a prior payment plan has been set up. **Once we determine a payment is due, the patient will receive a call/email which information on balance due. Payment will be processed within 24 hours of the call/email.**

SUBMISSION OF CLAIMS

We will submit your insurance claims on your behalf to your insurance company. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services not covered by your insurance carrier.
Email to: info@dermsanantonio.com

PAYMENT OPTIONS

Our office accepts most credit and debit cards. Our office also accepts valid check or cash. There will be a $50 fee for all returned checks. Once we have a returned check for you, we may require that all future payments be with cash, money order, cashier's check or credit card. Anytime a co-pay, deductible or balance is due, we will charge the fee to your credit or debit card.

ELECTIVE PROCDURES/NON-COVERED PROCEDURES

Patients are required to pay the self-pay portion of elective/non-covered procedures prior to services being rendered.

CASH PAYMENT

If you wish to pay cash, you will always be provided a receipt so that you will have a record of your payment. Please make us aware if you are not provided a receipt at any visit.

NON-CONTRACTED INSURANCE (Out of Network)

If you have an insurance plan that we do not participate with, you may or may not have out of network benefits. You will be considered a self-pay, uninsured patient if you do not have out of network benefits and you are financially responsible.

MISSED APPOINTMENTS/NO SHOWS/CANCELLATIONS, LATE FOR APPOINTMENT

We understand that you may not be able to keep all of your scheduled appointments or might occasionally be late. Failure to cancel or reschedule an appointment at least 24 hours in advance will be considered a no-show. ***We reserve the right to charge you $75.00 for this type of no-show appointment***.

For any of the following elective surgical procedure or elective aesthetic procedure, including, but not limited to sclerotherapy, kybella, subcision, PRP injections, Microneedling, and Physician/Physician Assistance/Nurse Practitioner administered chemical peels or laser procedures, a $250.00 deposit is required to schedule these types of appointments. **Failure to cancel or reschedule any of these types of appointments with at least 48 hours' notice will result in forfeiture of the $250.00 deposit.** For CoolSculpting, Cootone and Ultherapy a $500.00 deposit is required o schedule these types of appointments. **Failure to cancel or reschedule any of these types of appointments with at least 48 hours' notice will result in forfeiture of the $500.00 deposit. Failure to cancel or reschedule any** Excision of cysts, Lipomas and benign Nevi will result in a $250.00 no show fee for private pay patients.

Dermatology San Antonio reserves the right to permanently discharge a patient with more than one no-show appointment with 30 days written notice to the patient to seek medical help from another practice.

If you are running late on the day of your appointment due to unforeseen circumstances, please contact our office immediately so that we can determine whether we can see you that day or if we will need to reschedule your appointments. If you are more than 15 minutes late for an appointment, Dermatology San Antonio may reschedule your appointment.

REFERRALS

Email to: info@dermsanantonio.com

If your insurance carrier requires a referral or authorization for your visit, it is your responsibility to make sure that our office receives the current valid authorization. If you do not have a referral or authorization, we will be unable to treat you until a valid authorization/referral is obtained or full payment from you will be expected at the time of service. If you wish to pay in full, your insurance will not be billed.

FORMS AND MEDICAL RECORDS FEES

Copies of records for personal use or to be sent to another practice or facility, will be charged the allowed fee communicated by the Texas Medical Board and/or HIPPA regulations.

FMLA, Disability, Attorney Subpoenas, VA and MEPS/DOD $40.00

Dictated letters, extensive forms with review of medical records $15.00 per page

CONSENT TO TREATMENT

As a consenting adult and/or legal guardian, I agree to permit the physicians and staff at Dermatology San Antonio to provide medical care to myself, my child or the patient I represent, as applicable. By signing below, I agree to permit the physician and staff at Dermatology San Antonio to perform necessary or appropriate medical care including physical examination, diagnosis, photographing area of assessment and treatment. _________

AUTHORIATION TO RELEASE INFORMATION

I authorize Dermatology San Antonio to release any medical information including diagnosis, x-rays, test results, reports, and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, continuity of care and medical treatment, as required or permitted by law. _________

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans, to Dermatology San Antonio. I understand that I am responsible to follow up with the insurance plan due to any discrepancy in coverage. I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Dermatology San Antonio to release all information necessary to secure payment. _________

I have read the Authorization for Consent for Treatment, Release of Medical Records, and Assignment of Benefits.

____

Signature   Date

Patient Name (PRINT): ____

____

Email to: info@dermsanantonio.com

Signature Date

Name of Responsible Party (PRINT): ____

Email to: info@dermsanantonio.com