Financial Responsibility Policy

LAKE LOVELAND DERMATOLOGY, PC

Thank you for choosing Lake Loveland Dermatology as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality of healthcare. We ask that you read and sign this form to acknowledge your agreement and understanding of our financial responsibility policy.

1. **You are financially responsible for payment in full of all charges incurred regardless of insurance coverage. If your insurance company denies payment or makes partial payment, you are responsible for the balance due (to the extent permitted by applicable law). Further, you acknowledge you are aware that if any of the following circumstances apply, they may cause your insurance company to deny payment or make partial payment. This list is not exhaustive – your insurance company may deny payment or make partial payment for other reasons – it is your responsibility to verify that your insurance company will pay the charges incurred.**

   - If you fail to accurately and fully complete any forms or provide any information requested by your insurance company.
   - If you fail to pay your insurance premiums when due.
   - If there is any miscommunication between you and your insurance company or between your insurance company and Lake Loveland Dermatology, P.C.
   - If your insurance plan does not cover the services provided or the equipment used.
   - If you have not obtained a referral or authorization required by your insurance plan.
   - If you fail to comply with any of the terms of your insurance plan.
   - If Lake Loveland Dermatology, P.C. is not a contracted provider with your insurance plan.
   - If Lake Loveland Dermatology, P.C. is outside the network for your insurance plan.

   If any of the above conditions apply, your insurance company may deny payment or make partial payment. This list is not exhaustive; your insurance company may deny payment or make partial payment for other reasons. It is your responsibility to contact your insurance company to verify that it will pay the charges incurred. If your insurance company denies payment or makes partial payment for any reason, you are responsible for the balance due (to the extent permitted by applicable law).

2. You (or your guardian, if you are a minor) are ultimately responsible for payment of the costs incurred for treatment and care. We are pleased to provide billing for our contracted insurers. However, you are required to provide us with correct and updated information about your insurance at the time of your office visit.

3. You are responsible for payment of deductibles, co-insurance, co-payments, and costs of services not covered by insurance. For your convenience, we accept cash, check and most major credit cards at our office.

4. Costs for services that are unknown at the time of consultation will be billed to you. You are responsible for payment of these costs in a prompt fashion.

5. Please let us know if you need to cancel or reschedule your appointment. If you do not call to cancel your appointment at least 24 hours prior to your appointment or you do not show up for your scheduled appointment, or you show up more than 30 minutes late for your appointment, you will be billed $50 and will be responsible for payment of such fee.

6. You are responsible for all costs and expenses associated with or incurred in connection with our enforcement of this Financial Responsibility Policy Form, including, but not limited to, charges for returned checks, collection agency fees, court filing fees and attorney's fees.

Receipt of Financial Responsibility Policy

I have been offered a copy, read, understand and agree to the provisions of this Financial Responsibility Policy Form and agree to pay Lake Loveland Dermatology promptly all amounts for which I am responsible under this form.

I agree that I am financially responsible for payment in full of all charges incurred regardless of insurance coverage (to the extent permitted by applicable law). I am aware that my insurance company may deny payment or make partial payment and I agree that I will be responsible for the balance due (to the extent permitted by applicable law). I am aware that it is my responsibility to contact my insurance company to verify that it will pay for charges incurred.

Signature of Patient or Guardian _____ Date _____

Print Name _____ Patient Name (if different) _____

Please initial the following statement(s) if it applies to your visit today:

_____ ***I hereby acknowledge that I do not have or do not wish to provide my health insurance for claim. Therefore, Lake Loveland Dermatology will bill me directly as a SELF PAY patient for all services rendered.***

_____ ***I hereby acknowledge that I have not brought proof of medical insurance with me to my appointment today and understand my network benefits cannot be verified at time of service. If it is later determined Lake Loveland Dermatology is out of my network, I understand I will be billed directly as a SELF PAY patient for services rendered.***

Assignment and Release

1. I have insurance coverage and assign all medical benefits, if any, otherwise payable to me for services rendered.
2. I understand that I am financially responsible for all charges whether or not paid by insurance.
3. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
4. I authorize the use of this signature on my insurance submissions.

Signature of Patient or Guardian _____ Date _____