

PPD

Porter Premiere Dermatology
& Surgery Center

Office Financial Policy

Patient Name: _____ DOB: ___/___/___

Dear Patient:

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Medicare:

We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:

- a. The annual deductibles
- b. Co-payments
- c. Charges for non-covered or cosmetic services*

* You will be asked to sign an **Advanced Notice of Liability Form** in the event that a service is provided which we know is not covered by Medicare.

If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap 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 will be responsible for the balance.

Non-Medicare/Commercial Plans:

If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:

- a. The annual deductibles
- b. Co-payments
- c. Charges for non-covered or cosmetic services

In the event that you, as the patient, or we, as the physicians, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

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Office Financial Policy (cont.)

For non-Medicare patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:

We will file both your primary and secondary insurance. If we do not receive payment from your primary or secondary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.

Delinquent accounts may result in your account being turned over to a collection agency, credit bureau reporting and/or discharge from the practice. After 90 days of non-payment, your account will be turned over to collections.

If you require us to transfer your records to another physician, other than your primary or referring physician, there will be a nominal fee. This fee must be paid prior to transfer of the records.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Signature of Patient

____/____/____
Date