PREMIER DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC
A FOREFRONT DERMATOLOGY PRACTICE

Patient Communication & Financial Policies

The Following are internal policies set in place by the administration of Forefront Dermatology, S.C., d/b/a Premier Dermatology ("Forefront").
Signature is required before services can be provided.

Patient Communications**:** Confidential messages may be left on your voicemail or answering machine at the preferred number(s) you have provided to Forefront or with a friend or family member who answers the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such message may include, without limitation, reminders of upcoming scheduled appointments information regarding your pathology or laboratory tests, billing information, or answers to medical questions you may have inquired about to our staff. Forefront may also communicate with you via e-mail, text message, or post card to your home address provided such method complies with applicable HIPAA communication standards. You understand that you are not required to agree to this provision in order to receive treatment.

Research: I authorize Forefront to contact me regarding any research study in which I may be eligible to participate relating to my care.

Insurance Filing: As a courtesy we will bill your insurance company for charges incurred at our clinic. Please remember your health insurance is a contract between you and your insurance company. Our office will make two attempts to settle any outstanding bill with your insurance company. If your insurance deems a service to be not covered by your insurance plan you will be responsible for the balance of this service and you expressly agree to pay for such non-covered services. Claims not paid by your insurance carrier within 90 days will be considered a non-covered service. We will furnish information required by the insurance company to receive payment. Benefits should be paid directly to the Practice from your insurance company, if your insurance company pays copays, coinsurance, or other similar charges. I hereby assign to Forefront all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

Bad Debt & Bankruptcy Account Status: I realize that if my account is in bad debt or bankruptcy status I will be required to pay $150.00 prior to my scheduled appointment. This payment will serve as a down payment toward services to be rendered at the future encounter. If, after the provider has billed for services and/or the insurance has responded, the practice determines that I do not owe the $150.00 for the current encounter (and if I am not currently under bankruptcy or any other insolvency protection from collection on past debt) the practice will review my account to see if I owe a balance on any other recent encounters or if I owe anything to Americollect, the practice's collection agency. If it is determined that I do owe on past balances and am not protected from collection by applicable law, the practice will apply the remaining amount towards such amounts owed. If I owe less than what was overpaid on the account a refund will be returned to me for the appropriate amount. I realize that if my account is sent to collections, Forefront may alternatively elect to dismiss me as a patient from the practice. If I pay off my account with Americollect, my account will be returned to good standing status with the practice and I will not be required to pay $150.00 prior to appointments unless I am placed into collections in the future.

Non-sufficient Funds: A $35.00 charge will be added for any non-sufficient funds notice from the bank. If your account is sent to collections and we have to litigate in court, your visit/s with our office may become a matter of public record.

Medicaid Insurance Coverage (*ALL patients must fill this out*)

At this time I, _____ warrant and represent that I (DO) or (DO NOT) have **Medicaid** health insurance coverage.
Print Your Name ***circle one***
If we find at a later time that you did not provide accurate information above, you will be responsible for the balance of the charges incurred. It is your responsibility to inform our office if you acquire any type of Medicaid coverage at a later time. If you don't provide the updated information to our office you may be responsible for the balance of your bill. Not all locations and providers participate in Medicaid programs. The patient will be responsible for the full amount of services provided when this circumstance is applicable.

Non-insured Patients: Non-insured patients will be charged a fee prior to seeing a provider on the date of service. These funds will be allocated to the services rendered by the provider for that day however these fees serve only as a down payment and are not considered payment in full. The down payments are as follows:
New patient Office Visit: $178 Established Patient Office Visit: $150 Excision Visit: $800 MOHS Visit: $1,000

Final charges will be determined after the provider sees the patient and a complete assessment is made. The provider may require payment in full for procedural services prior to rendering such a service. Additional fee information is available upon the patient's request. A statement with the balance due for services provided will be mailed to you within a few days. If the balance is paid in full within two weeks from the date of the statement, a 20% discount for cash/check or a 15% discount for credit card will apply. This discount does not apply to *Cosmetic procedures and injectables*. **_____** ***Initial***

Co-payments, Co-insurance, Deductible, & Cosmetic Procedures: Payment is due on the date of service prior to seeing the provider. Deductible amounts may be collected prior to the physician completing the service. Payment for a cosmetic procedure is due in full prior to treatment. There are no returns on cosmetic products sold unless such products are defective or, in the opinion of your provider, caused an adverse reaction.

Procedure Pricing
I understand that procedure estimates are only provided in writing. Written estimates must be requested prior to the appointment.

X _____ _____ _____/ _____/_____ until revoked
Signature of Patient or Legal Representative *Relationship to Patient* *Date*

*DOB:*_____