

## OFFICE POLICIES

Thank you for choosing Colorado Center for Dermatology & Skin Surgery for your healthcare needs. To help us fulfill our mission to provide personalized and exceptional care to each of our patients, we have developed office policies to create a productive relationship between you and our team of healthcare providers. Our team cares greatly about your health and wellness and will provide recommendations and treatment options to help. We expect that you will abide by those recommendations and follow instructions including medications, testing, and follow-up visits. In addition to the medical care provided, understanding your financial and patient responsibility are essential components in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we have provided the following information regarding our office policies, as such may be amended from time to time without prior notice.

### Required Documentation

**Photo Identification:** In order to protect you against identity theft for services, we request and keep on file a copy of your photo identification issued by a local, state, or federal governmental agency (e.g., Driver's License, Passport, Military Identification, etc.).

**Insurance Card:** If we participate in your insurance plan, we request and keep on file a copy of your current insurance card to facilitate the submission and processing of your claim. If you do not provide your insurance card when you check-in, our office will not be able to submit your claim to your insurance carrier, but, rather, you will be considered a self-pay patient whose payment in full is required at the time of service.

## INSURANCE & FINANCIAL POLICIES

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we offer the following information regarding our insurance and financial policies.

Your insurance is a contract between your insurer and you. It is your responsibility to know and understand the terms, guidelines and limitations of your plan, including your co-pay, deductible and co-insurance obligations. It is also your responsibility to advise us of any changes in your insurance, your address, or your employer.

### Medicare & Contracted Insurance Plans

If you are on traditional Medicare or are a member of a health plan we participate with, we will submit your claim to your insurance company. Our team will verify your benefits and collect any co-payment, deductible, coinsurance, and/or any non-covered services obligations at the time services are rendered. After insurance processing, you will be billed for any outstanding amounts.

### Referrals

If your insurance plan requires a referral, please contact your primary doctor's office at least two weeks prior to your appointment date. It takes most insurance companies at least one week to receive the referral authorization. Please call our office at least three business days prior to your appointment to confirm that your referral has been received.

### Secondary/Supplemental Insurance Plans

We will file your secondary claims as a courtesy. If your secondary insurance has not paid us within 30 days, the balance will become your responsibility.

### Non-Contracted Insurance Plans/Self-Pay

If we do not participate with your insurance carrier, payment in full is required at the time of service. We are happy to provide you with a copy of your bill and appropriate information regarding your visit for you to submit to your insurance company.

If you are self-pay/not insured, payment in full is required at the time of service. When you check-in for your appointment, we may require an initial deposit of \$75/\$130 (office visits), \$500 (excisions/procedures),

and/or \$1,000 (Mohs Surgery). Upon check-out, any deposits will be applied to your total balance and any outstanding balance will be due in full.

#### Cosmetic Services

Patients are financially responsible for all cosmetic consults and treatments at the time of service. This office does not bill insurance companies for cosmetic services. When you schedule your cosmetic appointment, we require an appointment deposit of \$50 (consults) and/or \$100 (treatments). When you check-in for your appointment, your appointment deposit will be verified as your initial deposit. Upon check-out, any deposits will be applied to your total balance and any outstanding balance will be due in full.

#### Pathology Fees

Depending upon specific factors, your provider may send the specimen to an outside lab for slide processing and interpretation. In those instances, patients or their insurance company will receive a separate bill from the outside lab.

#### Benign Lesions

Patients are financially responsible for the removal or treatment of all benign skin lesions unless they have met certain clinical criteria, including, but not limited to change in quality or character, increase in size, pain, or bleeding. Billing insurance for such circumstances may represent fraud.

#### Minors

A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. We can submit the charges to an absent parent's insurance only with signed permission from the policyholder. The parent presenting the child for care is responsible for payment at the time of service. Any patient over the age of 18 will be held financially responsible for all charges incurred.

#### Outstanding Balance

If you have an outstanding balance on your account and/or such account is delinquent, we may require payment in full prior to or at the time of your next appointment.

#### Payment Methods

We accept cash, check, and most major credit cards.

#### Returned Check Fee

A \$25 fee will be added to your account balance in addition to the amount of the check returned for insufficient funds. This total (including original amount and fee) must be paid by cash or credit card within 7 days.

#### Collection Fees

If your account is assigned to a collection agency, you will be responsible for any fees charged by the collection agency along with any other collection costs, reasonable attorney's fees, and court costs.

### **CANCELLATION AND NO-SHOW POLICY**

We understand that situations arise in which you must cancel your appointment; however, missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. It is therefore requested that if you must cancel your appointment you provide one business day notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than one business day, we are unable to offer that slot to other people.

Appointments that are cancelled with less than one business day notice may be subject to the following cancellation fees: \$50 (office visits/consults), \$100 (cosmetic treatments), and/or \$150 (surgical/procedural). Additionally, the full amount of any deposits may be forfeited in such instances.

Patients who do not show up for their appointment without a call to cancel an appointment will be considered a NO SHOW. Patients who No-Show two (2) or more times in a 6 month period, may be dismissed from the practice thus will be denied any future appointments. No-Show Patients may also be subject to the cancellation fees set forth above.

The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within one business day. If you reschedule within one business day, fees in this instance may be put towards your service or waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to our office at (303) 761-0906.

## **OTHER POLICIES**

### Prescription Refills

Please plan ahead for prescription refills. We ask that you contact your pharmacy three (3) to five (5) days prior to needing a refill. If you are out of refills, the pharmacy will contact our office for physician approval. Please note, we will only refill prescriptions during our normal business hours. We will not refill prescriptions if you are outside the recommended follow-up window. As a general rule, no refills will be given for patients who have not been seen in the practice during the past twelve months for that specific prescription.

### Medical Records

Medical records requests and/or completion of forms (e.g. disability, life insurance, cancer policies, etc.) may be subject to fees determined by state law, contractual agreements, and/or office policies. Medical records requests require time to be processed and cannot be provided the same day requested.

### Minor Patients

All minors are required to have a parent/legal guardian present with them for each appointment. By law, we are required to have a consent from a legal guardian to provide treatment to a minor. If a parent or guardian is unable to attend an appointment with the minor, then a signed and dated authorization to treat a minor is required prior to the appointment. If a minor comes to the office unattended and we do not have a signed and dated authorization from the parent/legal guardian for a specific day(s) of treatment, we will be unable to see the patient at that time, and the appointment will have to be rescheduled.

### Lab Results

If you have labs or test reports at our office, please make sure to call if you have not heard from us within 7-10 days for your results. Please do not assume that your results are negative if you have not heard from us; it is possible that we have not received your results, or that we were unable to get into contact with you.

### Annual Skin Cancer Screening Exams

To ensure the best dermatological care, we strongly encourage our patients to have a full-body screening exam at least annually. If such exam cannot be performed at your initial visit due to the time needed to address your primary concerns, please make sure that you schedule an appointment as soon as possible.



## AGREEMENT TO OFFICE POLICIES

My signature below indicates that I have read, understand and will comply with the information contained within the practice's Office Policies (last revised June 26, 2017). I understand that these policies are subject to change without prior notice and that I may request a copy of the current policies at any time.

\_\_\_\_\_  
Signature of Patient (or Legal Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Print Name of Legal Representative (if applicable)