



OFFICE COLLECTIONS ACKNOWLEDGMENT & AUTHORIZATION

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 collections policies to create a productive relationship between you and our team of providers.

This form<sup>1</sup> outlines our office procedures for patients with active, in-network medical insurance coverage<sup>2</sup>:

- As a courtesy before your appointment, we will complete an insurance verification based on the information you have provided to our office.
In accordance with our Office Policies, any co-payment, deductible, coinsurance, uninsured/self-payment, and/or any non-covered services obligations are due at the time services are rendered.
At your appointment, we will collect (i) any applicable co-payment or (ii) a deposit toward any applicable remaining deductible. Such deposit amount<sup>3</sup> will be calculated as follows:
Mohs Surgery: \$1000 deposit or up to the remaining deductible, whichever is less
Excision: \$500 deposit or up to the remaining deductible, whichever is less
New Patient Office Visit: \$90 deposit or up to remaining deductible, whichever is less
Established Patient Office Visit: \$50 deposit or up to remaining deductible, whichever is less
Your insurance carrier(s) will process the claim, pay their portion, and transfer any applicable balance to your responsibility per your benefit coverage.
Our office will apply any applicable co-payment and/or deposit toward your patient responsibility. If you have an outstanding balance, you will receive a statement and be obligated to remit payment. If you have a credit on your account, you will receive an account credit or refund<sup>4</sup> for any overages paid.
You may pay your outstanding balance with your preferred method of payment within 25 days of your initial statement. If you do not pay your balance in full within 25 days, then, pursuant to the credit card authorization below, we will automatically process your outstanding balance and send a receipt to the email on file.

My signature below indicates that I have read, understand, and will comply with the information contained in this Office Collections Acknowledgment & Authorization.

Signature of Patient (or Legal Representative) Date

Print Name of Patient Print Name of Legal Representative (if applicable)

REQUIRED<sup>5</sup>: I hereby authorize Colorado Center for Dermatology & Skin Surgery to charge any outstanding account balances not paid within 25 days of the initial statement to the card that is securely stored on file.

Card Type (circle one): Visa Mastercard AMEX Discover Other:

Last 4 digits of Account Number<sup>6</sup>: Expiration Date:

Name on card (please print):

Signature Date

For Administrative Use Only: Date S.S. (initials):

1 This form replaces any prior Office Collections Acknowledgment & Consent or Authorization forms that you may have previously signed.
2 Without active, in-network insurance coverage, you are considered "self-pay" and payment in full is required in accordance with our self-pay policies.
3 Deposit amounts are subject to change from time to time, as our office deems necessary and appropriate.
4 For any credit balance that is less than \$5.00, our office will mail a refund check only upon request within 180 days of your date of service.
5 This card authorization is valid until revoked in writing and is required for all patients. It is your responsibility to notify us of any changes to your account. If your payment is denied for any reason, you may be assessed processing fees. If you do not provide a valid card authorization, we may (i) require full payment at time of service based on your estimated or potential out-of-pocket responsibility or (ii) refuse to provide service.
6 Please do not write your full account number. The authorized card will be swiped, read, or entered directly into our secure credit card processing system.