SPECTRUM
DERMATOLOGY OF SEATTLE

FINANCIAL POLICY

Thank you for choosing Spectrum Dermatology of Seattle for your care. We are honored to be of service to you. The following is a statement of our financial policy. We want you to understand it and be comfortable with it. We require that you read it and sign it prior to receiving evaluation or treatment from us. Please do not hesitate to ask questions or discuss any concerns.

Forms of Payment: We accept cash, check, VISA, MasterCard, and AMEX.

Credit Card on File: We require that you place a credit card on file with our office (see our Credit Card on File policy).

Patients with Insurance: We are able to bill most insurance carriers for you, both primary and secondary. However, this is not a guarantee of payment, therefore it is important for you to be aware of your insurance coverage, benefits and limitations. We bill your insurance carrier as a courtesy; ultimately you are responsible for the full charges of your visit. Your insurance policy is a contract between you and your insurance carrier. Since we are not party to that contract, you are responsible for understanding how your insurance works (For example: Is a referral required for your visit with Spectrum Dermatology of Seattle? How much is left to pay on your deductible?). We do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care. If your insurance carrier declines a claim due to inaccurate or incomplete information you have provided to us or to them, we may still bill you directly for the unpaid balances. We are not obligated to wait for you to resolve a dispute with your insurance carrier before seeking payment from you. As a courtesy, we will help you as best we can to get proper and timely payment from your insurance carrier.

Your signature below authorizes payment of medical benefits to Spectrum Dermatology of Seattle for any services furnished by providers of Spectrum Dermatology of Seattle. You authorize the physician and clinic to release any information to process insurance claims. This authorization is in effect indefinitely until revoked in writing.

In Network Coverage: If we have a contract with your insurance carrier, then the maximum financial responsibility (cost of your visit) for you and your insurance carrier combined is determined by our contract with them, and is called the "allowable fee" for the services rendered. Your copayment is due at the time of your visit. Once your insurance carrier processes your claim, we will bill you for the remaining balance as per our Credit Card on File policy.

Out of Network Coverage: If we do not have a contract with your insurance carrier, then the maximum financial responsibility (cost of your visit) is determined by Spectrum Dermatology of Seattle prices for the services rendered. Your copayment is due at the time of your visit. We will attempt to bill your insurance carrier for the balance. Your insurance carrier will reimburse at an out-of-network provider rate. It is your responsibility to make sure you have out-of-network benefits. Your remaining balance may be higher than a balance for the same services provided by an in-network provider. We will bill you for the remaining balance as per our Credit Card on File policy.

Medicare Patients: We bill Medicare for you. In order to do this, we must have your signature on file. We also bill Medicare Supplements and secondary insurance carriers for you. Your copayment is due at the time of your visit.

Non-covered Services: Cosmetic services cannot be submitted to insurance. Some insurance carriers deem certain procedures as cosmetic, such as skin tag removals. It is your responsibility to understand your benefits. Please see separate Notice of Cosmetic Dermatology Non-Covered Services and Self Pay Waiver.

Private/Self-Pay Patients: Private pay/uninsured patients are required to pay a **$250** deposit prior to the visit. Payment arrangements must be made for any future services. Procedures, biopsies and laboratory testing will incur separate fees as determined by Spectrum Dermatology of Seattle and outside laboratories we collaborate with, respectively.

Minor Patients: A parent or legal guardian must accompany minors at the time of the initial visit, and this person becomes the responsible party. Unaccompanied minors at subsequent visits are still expected to make copayments and update patient and insurance information as needed. If parents are separated or divorced, and the parents share financial or insurance responsibility for the minor, then accurate information and signed consents from both parents are required. In the event of any disputes, the parent or guardian who accompanied the minor at the initial visit is the responsible party for all balances.

Missed Appointments/Cancellations: If you no-show or cancel/reschedule an appointment without 24 hours' notice, there will be a fee (see table, below).

Scheduled Minutes	Fee
15	$75
30	$150
45	$225
60	$300

Returned Checks/Insufficient Funds Fee: If any payment (for example, a check) is returned due to insufficient funds, there will be a $50 fee.

Billing Service: Please pay your bill promptly. Your credit card on file will be used to pay the initial balance for a visit that is $200 or less (see our Credit Card on File policy). Our billing service, West Coast Dermatology Billers (WCDB), will then mail you a statement with remaining balance due. If a payment is not received, a second statement will be mailed to you. If again there is no payment, a collection letter will be mailed to you. Thirty days after the collection letter is sent to you, if there is still no payment, your account will be turned over to a collection agency.

Please do not hesitate to contact WCDB at 1-888-541-9232 with any questions or concerns about your statement, or if you wish to pay your balance by phone.

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. PLEASE READ AND INITIAL THE FOLLOWING STATEMENT.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ (Your Initials)

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", PLEASE READ AND INITIAL THE FOLLOWING STATEMENT

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ (Your Initials)

My signature below indicates that I have read, understand, and agree to this Financial Policy.

_____ Name of Patient or Responsible Party

_____ Signature of Patient or Responsible Party

_____ Date