FINANCIAL POLICY – PATIENT COPY

Thank you for choosing us as your health care provider. We are committed to providing quality medical care. Please read and sign this Financial Policy prior to treatment. You may be asked to sign this page again or as it is updated. Please let us know if you have any questions. As long as current and updated insurance information is provided at time of service, FD will submit all claims to the insurance plan(s) on file. However, there will be instances where services which are normally covered may be denied in situations related to certain conditions (for example, non-allowable diagnoses). Patients are responsible for these, and any cosmetic procedures not covered by insurance.

YOUR RESPONSIBILITY:

- I authorize Frontier Dermatology, or one of its affiliates ("FD") to bill my insurance carrier. I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my healthcare plan(s). I understand that it is my responsibility to verify with my insurance company if the provider is "in-network" to receive full insurance benefits. I certify that the information I provided related to my insurance coverage or other payment source(s) is correct.
- I understand that it is my responsibility to provide FD with accurate and updated insurance information and provide copies of all insurance cards, as well as updated address information to ensure receipt of statements. I consent to these statements being received via mail, email, and/or via text, although I may opt out of any of these options at any time. I further consent to receiving messages via these mediums for appointment reminders and other outreach.
- I will remit payment for all balances in a timely manner.
- I will pay my copay/balance at the time of service. I understand that FD accepts all major credit cards, cash, and check; and that all returned, and NSF checks will result in a $25.00 fee.

REFERRALS/AUTHORIZATIONS:

- Referrals and/or Authorizations are not a guarantee of payment. I am responsible for any balances classified as 'Patient Responsibility' by my insurance company. Any dispute with claim processing is between me and my insurance company. I am, ultimately, responsible for ensuring my Primary Care Provider (PCP) has provided FD with a referral or prior authorization prior to my appointment.

PAYMENT ARRANGEMENTS:

- I understand that FD may ask for my permission to securely store my credit card information for future payments, but it will not be stored without my consent.
- If my card on file expires or payment cannot be processed for any reason, I will promptly call FD's office to reinstate my payment plan before defaulting on a payment.
- Past Due balances must be settled prior to making an appointment or being seen for subsequent appointments.

GENERAL INFORMATION:

- Per the Office of the Inspector General, providers cannot change coding to obtain payment; this is illegal and falls under the "False Claims Act" and is considered Fraud and Abuse.
- If you present for a Cosmetic Appointment and have medical questions or concerns that result in what the AMA defines as an office visit or another medical procedure, the visit and subsequent procedure(s) will be submitted to your insurance. You will be billed according to your individual insurance plan benefits. Payments made toward a Cosmetic treatment or package will be applied to medical balances if left unused after 2 years.
- Pursuant to current AMA and CPT guidelines, all procedures (such as biopsies, pathology, liquid nitrogen/freezing, benign removals, skin tags, etc.) are billed separately and are not included in the office visit. Your chart note(s) will be reviewed by a certified coder for accuracy. Should the coding need to be changed, based on CPT coding guidelines, defined by the AMA, you will receive a bill for any remaining balance, if applicable.
- Additional skin specimen pathology stains, tests, or consultations may be required through an in-house and/or outside laboratory. These services will be billed separately and will not be included in bill estimates. There is no way to determine these fees until a dermatopathologist processes your specimen in the lab.
- When outside labs, x-rays, or other tests are ordered by FD, you are responsible for checking with your insurance regarding where you are authorized to have these studies done. An outside laboratory is used for these services; billing for these services is separate and you are responsible for any related balance. Any balance due outside of FD is between you and that agency. FD is not affiliated.
- No show appointments/cancellations less than 24 hours in advance will be charged $75.00 for a medical appointment and $150.00 for a missed surgery or cosmetic appointment.
- Some surgical procedures have a set number of days that are included in the package. This is called a "Global Period". Suture removals may fall within the global period, and no extra payment will be due. However, if the provider discusses or performs anything besides the suture removal, the visit is no longer considered global and will be billed to your insurance. The appropriate patient balance will be due.
- Product purchases are nonrefundable, and all sales are final.
- I consent to the provision of medical treatment which may include, but is not limited to, routine examination, diagnosis/diagnostic tests and general treatment to be performed by FD. I acknowledge that no guarantees or assurances have been provided to me as to the outcome of any examination or treatment. I understand that if further medical procedure(s) or surgery is required, I may need to sign specialized consents.

COLLECTION POLICY:

- If we have been unable to obtain payment in full or maintain scheduled payment arrangements from you after 3 months of repeated attempts, the account will be turned over to an outside collection agency, and you will be required to pay the remaining balance prior to scheduling a future appointment.

PATIENT ACKNOWLEDGMENT AND CONSENT

I acknowledge that I have received, read, and understood the information provided in Frontier Dermatology's intake forms, including the Notice of Privacy Practices (HIPAA) and the Non-Discrimination Notice to Patients.

Frontier Dermatology participates in the Health Information Exchange and will automatically enroll you. This secure exchange helps ensure your medical records are accessible to authorized providers, especially in emergency situations. If you'd like to opt out:

- Ask the front desk
- Email us at carequalityoptout@frontierdematology.com
- Visit patient portal

I confirm that the information I have provided is accurate and complete to the best of my knowledge and understand that this information is essential for my healthcare provider to deliver appropriate care.

I understand that my personal health information will be kept confidential and shared only with authorized healthcare professionals as needed for my treatment, in accordance with applicable laws and regulations.

I acknowledge my rights and responsibilities as a patient, including my right to privacy, my right to receive information about treatment options, and my responsibility to provide accurate information and follow the prescribed treatment plan.

I acknowledge that I have read, understood, and agree to Frontier Dermatology's Financial Policy. I authorize FD to bill my insurance and accept financial responsibility for any charges not covered, including those deemed patient responsibility or cosmetic. I agree to provide accurate and updated insurance and contact information, pay all balances in a timely manner, and understand that unpaid balances may result in collections or impact future appointment scheduling. I consent to receive communications via mail, phone, email, or text, with the option to opt out of electronic messages.

I authorize benefit payments to be made directly to my provider at Frontier Dermatology and consent to the release of medical or other necessary information to process insurance claims. If I do not have medical insurance, I acknowledge that I am responsible for payment at the time of service.

By signing below, I consent to the terms outlined above and in the intake forms. I understand that this is a legal document.

_____ _____

Printed Name of Patient (or Legal Guardian, if signing for patient) **Date of Birth**

_____ _____

Patient Signature (or Legal Guardian) **Date**

PATIENT DEMOGRAPHICS		
Today's Date:	Patient Date of Birth:	Patient Age:
Patient Legal Last Name:	Patient Legal First Name:	
Chosen Name:		
Sex Assigned at Birth:	Legal Sex (gender on ID card):	
Gender Identity:	Pronouns:	
Language:	Ethnic Group:	Race:
Preferred Contact Method: ☐ Patient Portal ☐ Phone ☐ Email ☐ Unspecified		
Home Phone:	Work Phone:	Mobile Phone:
Preferred Phone: ☐ Home ☐ Work ☐ Mobile		
Email Address:		
Would you like to opt into email notifications? ☐ Yes ☐ No		
Mailing Address:		
City, State, and ZIP Code:		
Emergency Contact Full Name:	Emergency Contact Phone:	

GUARANTOR (REQUIRED IF PATIENT IS UNDER 18 YEARS OF AGE)		
Patient's Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Guarantor Last Name:	Guarantor First Name:	
Guarantor Date of Birth:		
Contact Information Same as Patient's? ☐ Yes ☐ No (complete information below)		
Mailing Address:		
City, State, and ZIP Code:		
Home Phone:	Work Phone:	Mobile Phone:
Email Address:		

PRIMARY CARE PROVIDER AND REFERRING PROVIDER
Who is your primary care provider?
Were you referred to our office? ☐ Yes ☐ No If yes, who is the referring provider?

PRIMARY INSURANCE	
Do you have health insurance? ☐ Yes ☐ No	
Insurance Name:	Subscriber ID#:
Are you the policy holder? ☐ Yes ☐ No	
If no, patient's relationship to policy holder: ☐ Spouse ☐ Child ☐ Other:	
Policy Holder First Name:	Policy Holder Last Name:
Policy holder Date of Birth:	Policy holder Birth Sex:
Is the billing address the same as the patient's? ☐ Yes ☐ No (complete the information below)	

See back side →

Mailing Address:		
City, State, and ZIP Code:		
Home Phone:	Work Phone:	Mobile Phone:
Preferred Phone: ☐ Home ☐ Work ☐ Mobile		

SECONDARY INSURANCE		
Do you have a secondary health insurance plan? ☐ Yes ☐ No		
Insurance Name:		Subscriber ID#:
Are you the policy holder? ☐ Yes ☐ No		
If no, patient's relationship to policy holder: ☐ Spouse ☐ Child ☐ Other:		
Policy Holder First Name:		Policy Holder Last Name:
Policy holder Date of Birth:		Policy holder Birth Sex:
Is the billing address the same as the patient's? ☐ Yes ☐ No (complete the information below)		
Mailing Address:		
City, State, and ZIP Code:		
Home Phone:	Work Phone:	Mobile Phone:
Preferred Phone: ☐ Home ☐ Work ☐ Mobile		