PATIENT FINANCIAL POLICY & PATIENT RESPONSIBILITY NOTICE

Thank you for choosing Colorado Dermatology Specialists for your skin care needs. We are committed to providing you with the highest quality care. A copy of this policy will be provided to you upon request.

Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and us.

Colorado Dermatology Specialists provides many different types of medical services within our practice. Many insurance carriers have their own specific criteria set for how frequently an exam, test or procedure can be performed in addition to not paying for certain types of services such as routine/screening testing i.e. blood work, removal of certain skin conditions, etc. Therefore, Colorado Dermatology Specialists will not be responsible for knowing your insurance coverage.

For those insurances with whom we participate, we will file a claim on your behalf directly to the insurance carrier for payment. You are responsible for all copays, coinsurance, deductibles, and non-covered services. We are obliged to collect your copay at the time of service per your insurance company. We accept cash, debit card, check, MasterCard & Visa.

INSURANCE: If you are insured with a plan we are not contracted with, payment in full is expected at each visit. Please contact your insurance company with any questions you may have regarding your coverage. It is advised that you call and confirm with your insurance carrier that we are contracted with your insurance plan. Please understand that we cannot waive deductibles, coinsurances or copays that are required by your insurance. This is a violation of insurance rules and can be punishable as fraud. Our fees are representative of the usual and customary charges for our area.

IT IS YOUR RESPONSIBILITY:

1. To be familiar with your insurance coverage, benefits and rules.
2. To notify our office of any insurance changes prior to the time of the visit.
3. To bring your insurance card(s) and photo ID to each visit.
4. To obtain a referral from your PCP if your insurance plans require one. If you do not have the required referral, you may either be required to pay the full fee at the time of your visit or reschedule your visit.
5. To be prepared to pay all copayments, coinsurance and deductibles according to your insurance plan at the time of your visit.

IDENTIFICATION: All patients must complete our patient information forms before seeing a provider. We will obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the claim.

NON-INSURED PATIENTS: Patients who are not covered by an insurance plan are responsible for services rendered at the time of service. For those patients who are unable to pay for service in full, a minimum of 50% of the charges are due at the time of service. Payment for any remaining balance is payable within 30 days of the date of service.

MINOR PATIENTS: For all services provided to a minor patient, we will look to the adult accompanying the patient and the parent or guardian with custody for payment. The accompanying adults must provide a photo identification and consent to treatment.

NONPAYMENT: If your insurance company does not pay your claim in 45 days as required by Colorado State Law, the balance will automatically be billed to you. If your account is over 30 days past due after the insurance company has paid their portion and a statement has been sent out, partial payment will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this practice. In the event of finding it necessary to turn your unpaid balance over to a collection agency, all collection fees and/or legal fees will be owed in addition to the remaining balance. If this occurs, you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

CONSENT TO TREAT: This consent provides us with your permission to treatment at this office, as requested by you, or diagnosed by your physician. This consent will remain fully effective until it is revoked in writing. You have the right to discuss the purpose, potential risks and benefits of any treatment or procedure. If you have any concerns about any treatment or procedure, we encourage you to ask questions prior to treatment. Your consent to treatment acknowledges that you understand and agree to the procedure and our billing for any/all services rendered. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

ADDITIONAL PRACTICE RELATED FEES AND POLICIES

$25 Fee	"No Shows" (Failure to provide cancellation notice 24 hours prior to your scheduled appointment).
$25 Fee	Request to complete Life, Disability, FMLA & many other various types of independent health forms. Please allow 3-5 days for completion of such forms.
$40 Fee	Returned checks for nonsufficient funds, which is a charged back processing fee to the patient. We will be unable to accept any personal check until account balance and associated service fees are paid in full. If this is a repeated occurrence, we will only be able to accept cash or credit card as method of payment.
Other	Biopsy, Pathology and Lab samples sent to labs outside of our office are billed independently of Colorado Dermatology Specialists. You may receive a bill from the outside lab and will be responsible for payment to that facility.

ACKNOWLEDGEMENT: I have read and agree to abide by the financial policy of Colorado Dermatology Specialists. Any questions I have were answered to my satisfaction. I understand that this office will submit a claim to insurance for ANY and ALL services rendered during my appointment per this consent.

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Patient/Guardian Print Name Patient/Guardian Signature Today's Date