APEX SKIN CENTER
Dermatology & Mohs Surgery

Today's Date: _____

Patient Name: _____

Patient Date of Birth: _____

APEX SKIN CENTER FINANCIAL POLICY & CONSENT FOR TREATMENT

Thank you for choosing Apex Skin Center, PLLC for your dermatology needs. We are dedicated to providing the best possible care and service for you and your skin. Please understand that payment of your bill is considered part of your treatment. We realize the challenges of health care costs today and do our best to inform you of your personal and financial responsibility in obtaining care.

Effective Date: January 1, 2025.

Please read carefully and sign below to confirm your understanding. Please do not hesitate to ask if there are any questions.

1) **Consent for Treatment:** By signing this form, you authorize Apex Skin Center, PLLC, through its appropriate personnel to perform upon me, or the above-named patient, appropriate assessment and treatment procedures.
2) **Insurance:** Your visit is filed with your insurance carrier and you consent for Apex Skin Center, PLLC to bill your insurance company according to the most recent insurance information and insurance card(s) provided. It is the responsibility of the patient to provide accurate insurance and personal information including any preferred laboratory needs. You will be responsible at the time of service for any deductibles, copayments, or past due balances. If claims are denied due to lack of current insurance information, you will be responsible for the balance. If your insurance company has not paid on your claim within 45 days, you will automatically be responsible for the balance.
    a. **Network/Referrals:** It is your responsibility to ensure that this practice and the provider of services are in your insurance network and to obtain any referrals or authorizations required by your insurance plan. If your claim is denied because the practice is out of network or you failed to obtain a referral or authorization, you will be responsible for any balance.
3) **Usual and Customary Rates:** Our practice is committed to providing the best treatment to our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. The only exception to this policy is a plan where we are a contracted participating provider with your medical insurance.
4) **Medical Necessity:** Please be aware that some, and perhaps all, of the services provided may be deemed non-covered services or not medically necessary under Medicare and/or other medical insurance plans.
5) **Self-pay Appointments:** You understand and agree that if you do not have insurance or opt out of insurance coverage if permitted and elect to be seen as a self-pay patient, you have full financial responsibility for your visits and will pay for all services at the time of service unless other arrangements have been made.
    a. **Good Faith Estimates:** If uninsured, or if you request that covered services not be billed to insurance, you understand that you may request a Good Faith Estimate of the total fees that may be charged and that fees for all services must be paid on the date that services are rendered.
6) **Cosmetic Appointments:** Payment is expected in full at the time of service.
7) **Cancellation and Missed Appointments**: We understand that urgent issues arise and illnesses occur. When this happens, please call our office as soon possible to inform us. If not, a charge will ensue.
    a. In the case of missed appointments or late cancellations: You understand that it is your responsibility to cancel appointments greater than 24 hours in advance of the appointment, otherwise a $50.00 fee will

be billed to your account which is not covered by insurance plans. For missed surgical or cosmetic visits, a $200.00 fee will be charged to your account which is not covered by insurance plans.

8) **Requests for Medical Records and Form Completion:** We encourage use of our patient portal to access office visit notes and test results conveniently from home. Paper copies are available at a fee dependent upon chart volume. Medical records may be sent to another provider or healthcare facility at no charge. FMLA, cancer policies, and other such policy forms to be filled out will be charged a $10.00 fee.
9) **Accepted Payment Methods are:** Cash, Visa, Mastercard, Amex, Discover and personal checks with proper identification (valid Driver's license or photo ID). A $30.00 overdraft charge will be added to any insufficient funds amount on any returned checks.
10) **Credit Card on File:** Apex Skin Center, PLLC securely stores an updated credit card on file for all patients with commercial insurance. This information is stored securely with the same HIPAA-compliant software that protects your confidential medical information. Should you have a balance after your visit, we will electronically send out a statement. If that statement is not paid, a $25 late fee is assessed. If the statement remains unpaid after 14 days, any remaining balance will be charged to your card on file to avoid sending your account to collections. If the balance remains unpaid, this practice may refer the account to a collection agency and/or you may be dismissed from this practice. If you prefer to simply bill the card outright and avoid all such mailings, please notify us and we will accommodate.
    a. **Agreement:** By signing this form, you authorize Apex Skin Center, PLLC to bill your card on file as described above. Receipt of any transaction will be forwarded to the home address in our records. By signing you agree that you have read, understand, and abide by our stated financial policies. You also understand that failure to make payment when due is the basis for further action and agree to pay all costs of collection, including court costs and attorney fees.
11) **Golden Rule:** We strive to treat our patients with respect and empathy. Any breach of this agreement may result in a need to reconsider our relationship as patient and provider, including referral outside of our office for future care. First and foremost, we look forward to treating your healthcare needs and thank you. We understand the importance of your decision to trust our office for your healthcare.

Patient (Guardian) signature*:_____ Date: _____

*Signer must be the same name as the credit card on file. Thank you.