



Dermatology & Laser Institute
of Colorado, P.C.

9695 S Yosemite St, Ste 120
Lone Tree CO 80124
720-344-5252

OFFICE FINANCIAL POLICY

You must read and sign this policy prior to receiving treatment at our office.

Dear Patient,

We are pleased that you have chosen the Dermatology and Laser Institute of Colorado, to assist you with your medical and cosmetic dermatology concerns. Our staff is committed to providing you, your family, and friends with comprehensive care in a warm and supportive environment. Excellence is always our goal and we welcome the opportunity to serve you.

In order to establish an optimal relationship with our patients and to avoid misunderstandings; our staff is trained to consistently inform you of our payment policies. Payment is required for all services at the time they are provided. The only exception is when you are insured with a plan in which we participate. Our staff will make a good faith effort to pre-verify your insurance eligibility. For those insured patients, any applicable co-payments, co-insurance and/or deductibles may be collected at the time of service. We accept payment in the form of cash, check or Visa or MasterCard.

All self pay patients, which includes patients receiving cosmetic services, are required to pay, in full, at the time of service. For some procedures a deposit may also be required. This will need to be paid prior to scheduling the appointment.

Complete insurance information, including referrals from your Primary Care Physician, must be available to our office for all visits billed to your insurance company. Medical insurance is a contractual agreement between you and your insurance carrier(s). You are responsible for knowing the specifics of what each policy covers and notifying our office of any insurance changes. Co-Payments are **required** to be paid at each time of service. We will bill both your primary and secondary insurance plans for covered services under our contracted plans. If no payment is received from your insurance company due to failure to provide our office with up-to-date changes or inactive coverage, you will be responsible for the full amount due.

Monthly statements will be sent to you for payment of any balance due after your insurance carrier has paid its agreed upon share. If you do not respond to our monthly statement, a final statement will advise you that no further bills will be sent and your account will be turned over to a collection service. In the event that your account is turned over to a collection agency, an additional collection fee of \$10 will be added to your account balance. When applicable, a \$25 insufficient funds check fee will be added to your account balance. Once your account is placed in collections continuation of care will be available to you for emergency purposes only unless payment can be made in full to our office. Payments for collection balances can be made by cash or credit card; we will not accept a personal check.

Legal documents must be presented to our office for Guardianship or Power of Attorney. All children under 18 years of age must be accompanied by a parent or legal guardian. Proof of legal guardianship is required to be submitted with all other patient documentation. A person granted the ability to make medical decisions or to consent for treatment on behalf of the patient will be required to submit a legal Power of Attorney to our office. If these documents can not be provided before the patient is treated, you may be required to reschedule the appointment.

Your appointment time is reserved exclusively for you. We ask that you allow yourself 1 hour to be in our office. Should you need to cancel your appointment we ask that you provide our office advance notice of not less than 24 hours. In order to ensure timely scheduling of necessary medical surgeries for all patients, we do require 2 full business days notice of any cancellation of a surgical procedure. If less than 2 full business days notice are given, a cancellation fee of \$50 will be added to your account. Specialized cosmetic procedures also have requirements for cancellations. You will be informed of these when you schedule a cosmetic type appointment. Fees will be assessed for cancellations of cosmetic procedures with less than the required notice or for no show appointments. Family emergencies or weather related delays will be handled on a case by case basis.

All Sales are Final for purchases of skincare products sold by our office. In the event of an adverse reaction, please contact our office immediately.

Refunds, when applicable, are issued in the following way; all payments received by credit card are refunded to the original card used. Refunds for cash or check payments are returned by check only. Check refunds will be mailed to you within 10-14 business days. We do not issue cash refunds.

Our practice is dedicated to maintaining the privacy of your individual health information. We are required by law to maintain the confidentiality of this health information under the Health Insurance Portability and Accountability Act (HIPAA). We can not release or discuss personal medical information with spouses, parents of dependents who are 18 and older, or any other family member in your household. Patients who would like us discuss or disclose private information are required to sign a release form permitting such disclosure. You will be offered a copy of our office Notice of Privacy Practices.

Your signature below signifies that you have read and understand our office financial policy. Under this agreement you authorize treatment and the release of medical information to your primary care or referring physician, to consultants to process insurance claims (if needed and as necessary), insurance payments to be made directly to the practice, insurance applications and prescriptions. You also authorize the staff of the Dermatology & Laser Institute of Colorado to act as your representative for claims appeals when needed. You also acknowledge that you have been notified and offered a copy of the Dermatology & Laser Institute of Colorado Notice of Privacy Practices.

Please sign below and return this to our staff:

Patient or Guardian Signature

Date