

Financial Policy for Commercial Carrier (Non-Medicare/Medicaid) Patients
Premiere Dermatology & Surgery, L.L.C. Rev. 07/07

We are pleased to be able to continue to handle billing as a courtesy to you, however, it has become nearly impossible for us to keep track of the individual requirements, even within the same insurance company, of over 1,600 plans that we currently bill for our patients. The benefits, etc, vary depending on the type of contract negotiated by your employer.

PROVIDING QUALITY MEDICAL CARE IS OUR PRIMARY CONCERN. We are more than willing to provide that care within your insurance contract guidelines, if you let us know at each time of service what those guidelines are. Unfortunately, if you do not inform us of any changes or special requirements in your contract, and we subsequently order services, such as lab work, tests and/or hospitalization, that are NOT covered, we, or the selected medical facility, will have no choice but to bill you directly for those charges. **It is the PATIENT'S AND/OR GUARANTOR'S RESPONSIBILITY to know the particular requirements of your insurance contract.** Please understand that ***Premiere Dermatology & Surgery, L.L.C.*** cannot be expected to know these details.

Additionally, the following policies are in effect for *Premiere Dermatology & Surgery, L.L.C.* commercial carrier patients:

1. ALL payments, co-payments and/or deductibles are due at the time of service.
 2. YOU become immediately responsible for all charges that are submitted and denied by your insurance company and/or if your insurance carrier provides an incorrect billing address. You must inform us of any changes in your insurance prior to each office visit.
 3. ALL unpaid claims become the **PATIENT'S SOLE RESPONSIBILITY** if they are not paid at the end of **60 DAYS FROM THE DATE OF SERVICE.** YOU, the patient and/or guarantor, are ultimately responsible for payment of your medical charges.
 4. ALL unpaid patient accounts will be assessed a LATE FEE of \$10.00 or 1.5% (18% APR), ***which ever is greater***, each month the balance remains unpaid.
 5. ALL unpaid charges are subject to a collection activity if unpaid at the end of 90 days from the date of service.
 6. **A \$30.00 fee will be assessed on any and all returned checks.** If you *knowingly* provide us with an invalid check and/or incorrect personal information, *with the intent to avoid payment*, your account will be **Immediately** turned in to our collection agency, ***Benchmark Accounts Management.*** **(OVER)**
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7. IF your account is turned over to our collection agency, you will also be responsible for any and all additional costs, including, but not limited to, collection fees (30-50%), plus attorney fees, court costs, etc.

I HAVE READ, UNDERSTAND AND AGREE TO THE OFFICE POLICIES OF *PREMIERE DERMATOLOGY & SURGERY, L.L.C.*, STATED HEREIN, AND ACCEPT THE RESPONSIBILITIES DESCRIBED.

SIGNATURE of Responsible Party

Date

PRINTED NAME of Responsible Party

SSN for Responsible Party

AUTHORIZATION TO RENDER TREATMENT

I hereby give permission for my child/dependent _____ to
receive medical treatment from ***Premiere Dermatology & Surgery, L.L.C. Physician/PA.***

SIGNATURE of Responsible Party

Date