Damascus
DERMATOLOGY & SKIN
SURGERY CENTER
26215 Ridge Road, Damascus, MD 20872 ■ 301.253.1100

Also visit us at www.DamascusDerm.com

OFFICE POLICIES

OUR FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and practice, we have adopted the following policy. If you have any questions about the policy, please discuss them with our business manager. We are dedicated to providing the best possible care and services to you, and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. **PAYMENT IS EXPECTED FROM YOU, AT THE SAME TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES.**

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for whom we have an agreement, and will only require you to pay the authorized co-payments, deductibles, and coinsurance at the time of service. For **PPO Subscribers** with deductibles, it is the policy of our office to collect any payment due when services are rendered. This will be done similar to the manner when you check into a hotel or rent a car. It is office policy for a credit card number to be obtained at the time you check in and this information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At this time, any remaining balance owed by you will be charged to your credit card. For **HMO Subscribers,** the patient is liable for all service charges pertaining to procedures **NOT** listed on his or her referral.

If you have insurance coverage with a plan that we do **NOT** have a contract with, we will prepare and send the claim for you on an assigned basis. Typically out-of-network benefits are lower; therefore you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

LABORATORY AND PATHOLOGY BILLING

Your insurance may or may not cover your laboratory and pathology billing in full. You will be responsible for all laboratory and pathology charges not paid by your insurance. Payment is due upon receipt of a statement from our office or the billing laboratory.

COLLECTION POLICY

Any unpaid balance will accrue a twenty percent (20%) finance charge, monthly, after the account has lapsed past sixty (60) days. In the event any balance due hereafter is not paid as agreed, the patient will be responsible for additional charges by the collections company, which costs will not exceed thirty-five percent (35%) of said balance, including a reasonable attorney's fee.

CHECK POLICY

Your check must include your name, address, home number, and work number. There will be a check fee of $25.00 for all returned checks.

CREDIT CARD POLICY

WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. WE DO NOT ACCEPT AMERICAN EXPRESS OR DISCOVER. To ensure prompt payment, your credit card number will be used for current or future payments owed (e.g. co-payment, balance owed, etc.). You will be asked for your credit card at the time you check in. This is no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. All information will be held securely.

MINOR PATIENTS

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for treatment consent and payment.

MEDICATION REFILLS AND PRIOR AUTHORIZATIONS

Prescription refills and prior authorization requests should be made five (5) days in advance.

CONSENT FOR BLOODTESTING

In certain circumstances it may be necessary to perform screening bloodwork before prescribing a medication. This bloodwork may or may not include work up for sexually transmitted diseases, as dictated by the drug manufacturer and current research.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment. A $50.00 "no show" fee will be applied to your account if you fail to call to reschedule at least twenty-four (24) hours prior to your original appointment. A $100.00 "surgical no-show" fee will be applied to your account if you fail to call to reschedule at least twenty-four (24) hours prior to your original surgical appointment.

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