

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. Please also note that your biopsy or surgery specimen(s) will be sent to an appropriate in-network laboratory (Annapath Inc. or Mid-Atlantic Pathology Services) for processing into glass slides. These slides will then be read by Dr. Ilene Bayer-Garner, MD, for diagnosis. In extremely rare instances, Dr. Bayer-Garner may enlist an additional specialist for a second opinion if a complex diagnosis is being entertained and additional charges may occur.

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 in 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. Exceptions to this policy will be considered in emergency and/or extreme circumstances.

MEDICATION HISTORY:

I understand that Damascus Dermatology has implemented e-prescribing for its patients. I also understand that e-prescribing involves the ability for the practice to send prescriptions electronically to pharmacies, eliminating the need for a more time-consuming, and sometimes more costly approach to prescribing through paper, phone or fax. E-Prescriptions are fast, convenient, legible, secure, cost-effective and safe. The e-prescribing process also allows the health care provider to access critically important information about their patient's current and past medications from pharmacy benefit managers and community pharmacies. This information helps alert the provider to other potential medication issues with their patients and can improve safety and quality. I consent to the practice requesting and using my medication history from other health care providers or third-party pharmacy benefit payors for treatment purposes in connection with the e-prescribing process.

CORONAVIRUS/COVID-19:

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people. Damascus Dermatology has implemented preventative measures based on the most current Centers for Disease Control guidelines to reduce the spread of COVID-19; however, Damascus Dermatology cannot guarantee that you will not become infected with COVID-19. Furthermore, visiting Damascus Dermatology & Skin Surgery Center could increase your risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19. Such exposure or infection may result in personal injury, illness, permanent disability and death. I understand that the risk of being exposed or infected is the result of my actions. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to others or myself around me. Risks are including, but not limited to, personal injury, disability, liability, loss and death, or expense of any kind that I may experience or incur in my connection with my service at Damascus Dermatology. I hereby release, covenant not to sue, discharge, and hold harmless to Damascus Dermatology, its employees, agents, and representatives, of and from claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Damascus Dermatology and its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, and after service at Damascus Dermatology.

ACKNOWLEDGEMENT:

I have read and understood the all the policies of the Practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the Practice.

All information provided by the patient is deemed private under the Health Insurance Portability and Accountability Act (HIPPA) and will be used as follows only with patient consent. I hereby authorize Damascus Dermatology & Skin Surgery Center to furnish information to other providers, health care treatment facilities, and my insurance companies for purposes of treatment, payment, and health care operations. I hereby assign to the physician or provider all payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance. **I also acknowledge any outside laboratory is a separate entity from Damascus Dermatology & Skin Surgery Center and I am responsible for any laboratory fees.** Your signature below indicates that you understand and accept this policy.

This Patient Registration may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement.

Signature of Patient or Responsible Party

Date

Please Print Patient's Name