GRANITE BAY DERMATOLOGY AND LASER CENTER
SCOTT B. HEARTH, M.D.

**Financial and Practice Policies**

Dear Patient, Guardian or Guarantor:

There have been many changes in methods of payment for physician's services. We have found that patients are often confused by their insurance policies. The purpose of this letter is to provide information and help prevent misunderstandings. We strongly recommend you research your benefits prior to your office visit.

**YOUR RESPONSIBILITY**
Insurance coverage is not a guarantee of payment. You the patient, guardian or guarantors are ultimately responsible for payment of services rendered by this practice. There are several reasons why your insurance may not pay for your visit. These include:

- You have not met your annual deductible
- You have not received the proper referral or preauthorization for this visit or procedure
- These services are not covered by your insurance
- We are currently not contracted with your insurance

**See attached form**

**PAYMENT AT THE TIME OF SERVICE**
Any co-payments, co-insurance or deductibles must be paid at the time of service. Payments may be made by cash, check, Visa, MasterCard, Discover, and most debit cards. Any returned checks will incur a $25.00 administrative fee. **We require 24 hour notice for office visit and 48 hour notice to cancel any procedure appointment**. There will be a $45.00 charge assessed for any no-show or cancellations of office visits with less than 24 hours notice. A billing statement will be sent to you explaining these charges. All cancellations/no show fees must be paid prior to having another visit to our office. Most procedures done here in our office will require a deposit fee of $100.00 in order to hold your date/time for services. Failure to provide at least 48 hours notice prior to cancelling or rescheduling an appointment for a procedure will result in forfeit of deposit. The deposit will be applied to any insurance deductibles or co-insurance responsibility. After the claim is processed by your insurance company, partial or full amount of deposit will be refunded. For all non-insurance procedures deposit will be applied at time of service.

Our staff will take all necessary steps to get your services paid. Keep in mind your insurance policy is basically a contract between you and your insurance company. However, **you are ultimately responsible for the payment of services**. If your insurance company does not pay the practice within 60 days, you are responsible for paying any outstanding balances. If we later receive payment from your insurance company, we will refund any overpayment to you.

If past bills are sent to collections, there will be a surcharge to cover the cost of the collections agency. Once your unpaid balance is sent to the collections agency, payment must be made directly to the collection agency.

**LABORATORY & PATHOLOGY SERVICES**
Most insurance policies will only pay for laboratory or pathology services if processed at ***specific, designated*** labs. While we do our best, we cannot always determine with certainty which laboratory or pathologist your insurance carrier requires us to use. This means you could receive a bill from a laboratory if it is not contracted or if you have a deductible with your insurance carrier. Most lesions removed in our office are sent to a Pathologist for analysis.

**MEDICAL RECORDS**
Copies of your medical records may be obtained with written consent. The charge for this service is $25.00.

**MEDICATION REFILLS**
Please allow at least 2 business days to process requests for medication refills.

By my signature below, I acknowledge I have read and understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them. I also understand I could possibly be responsible for laboratory and pathology charges as well. This authorization is not limited in time.

_____ _____ _____
Signature of Patient or Responsible Party | Relationship to Patient (i.e. self, mother, father) | Date

_____ _____
Witness | Date

GRANITE BAY DERMATOLOGY
AND LASER CENTER
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# NOTICE OF PRIVACY PRACTICES

## ACKNOWLEDGMENT OF RECEIPT

I hereby acknowledge that I have received a copy of this medical practice's ***Notice of Privacy Practices (HIPPA Privacy Notice).*** I further acknowledge my understanding and agreement to the standards set forth in the notice. I understand that this practice will not use my Private Health Information for purposes other than those specifically described in the notice. Additionally, I understand that my Private Health Information may be used at the discretion of my physician or by his/her staff representative in order to facilitate my care with other physicians, laboratories/pathologists, or other healthcare professionals as necessary to render appropriate diagnosis and/or treatment.

Name of Patient:_____

Patient Date of Birth:_____

***If not signed by the patient, please indicate:***

Your name (please print):_____

Relationship:

☐ parent or guardian of minor patient

☐ guardian or conservator

To be in compliance with current federal government regulations, we are required to ask the following questions. Please understand that these questions are completely OPTIONAL and if you do not wish to answer them, please check the appropriate box.

What is your race: ----------

What is your ethnicity: _____

What language do you speak: _____

☐ I decline to answer these questions.

_____ _____

Patient Signature Date