NAME: _____

TURNER DERMATOLOGY FINANCIAL POLICY AND BILLING PROCESS

Payment Due: I understand that payment is due when service is rendered.

Co-pay, Co-Insurance and Deductibles: It is my responsibility to know what my co-pay, co-insurance and deductibles are and my obligation to pay at the time of service. If I am not able to pay my co-pay at the time of service, my appointment may be rescheduled and a $50 missed appointment fee will be charged. I will advise Turner Dermatology of any changes to my insurance, address, or phone number. A current, valid insurance card and drivers license or photo ID must be presented at each visit. If I am unable to present an insurance card and photo ID or if I am covered by an insurance plan that is not contracted by my provider, I understand that full payment for my appointment will be required in advance of my appointment. If for any reason my insurance company does not cover my visit, I will be responsible for 100% of the charges billed. Co-pays are collected during the check-in process and are due prior to seeing the provider. Co-pays will not be billed.

Referrals: If my insurance plan requires referrals, it is my responsibility to obtain one prior to my visit. If a referral is required and I do not have one, I understand that my appointment will be rescheduled and a $50 missed appointment fee will be charged.

Insurance Coverage: I acknowledge that the insurance cards I have presented are current and accurate.

Credit Card on File: Turner Dermatology requires a credit card on file at time of booking. This card and its information are securely stored by our online electronic medical record system. After your insurances have paid their portion of the medical claim and notified us of the amount you owe, you will be sent an email and have 60 days to pay or contest your balance. **You will not receive any additional notification prior to your card being charged after 60 days**. If the original card given changes, expires, or is denied for any reason, you agree to immediately give us a new, valid card that will replace the previous card on file for future transactions and the same Card on File policies will apply to it.

**Cards for your Health Savings (HAS) or Flex Savings (FSA) will not be accepted as an active credit card on file. You will have the opportunity to pay your bill using this method before being charged.*

Self Pay: I acknowledge that the insurance cards I have are current and accurate.

**If my insurance is INACTIVE in Modernizing Medicine, on the day of my appointment my visit will be considered SELF PAY and I will be charged the following rates:

-New patient $250, Established patient $175, Biopsy: 1st biopsy $150, 2nd and subsequent biopsies $100 each, Cryosurgery up to 14 lesions $150.

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Allergy Testing self pay rate is $550

Non-Covered Services: I understand that some services may be considered non-covered by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover and I understand that I am financially responsible for paying all non-covered services.

Non-covered medications/Cosmetic medications: I understand that non-medical medications such as Retin-A, Renova, Tretinoin, Retinol, Hydroquinone, etc., are typically not covered by insurance companies as they are deemed "cosmetic". I understand that if Turner Dermatology providers recommend a in office prescription or product, that I have the choice to purchase or request that the medication is sent to the pharmacy. I understand that the provider may send in a script under the request of the patient, but should the script be denied, any further requests will have an admin fee of $25 per interaction with the office. The fee will need to be paid prior to the script being altered/sent to another location. No prior authorizations will be submitted for non-covered or cosmetic medications. I also understand that Turner Dermatology works with a compounding pharmacy to provide these medications to patients IN-OFFICE. If I choose to use my FSA or HSA to purchase these medications, I understand that my HSA/FSA may still bill me for non-covered/non-medical/cosmetic medications.

Telehealth Services: I understand that telehealth services may be considered non-covered by my insurance plan. If I elect for telehealth, I understand that it is my responsibility to know what my insurance does or does not cover. I understand that I am financially responsible for paying all non-covered services. I understand that the out-of-pocket cost for telehealth is $150 and that I am responsible to pay this amount if my insurer does not cover my visit.

Laboratory and Pathology Services: You may be referred for outside laboratory services, including but not limited to blood work and pathology interpretation. These fees will be billed to your insurance, or to you, by the laboratory. All tissue specimens are sent to an independent dermatopathologist for evaluation. It is the patient's responsibility to verify whether their insurance covers any ordered laboratory tests and to ensure that all laboratory services are performed by a facility contracted with their insurance plan. Coverage and payment for these services are the patient's responsibility, and any charges not covered by insurance will be billed directly to the patient.

Participating Insurance Plans: If the practice is not a participating provider in my insurance plan, I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service.

Out-of-network: I understand it is the patients responsibility to find out if Turner Dermatology is in-network. I understand that I, as the patient, am responsible for any and all costs that accrue that my insurance will not pay due to being out of network. This includes, but is not limited to, blue lights, biopsies, surgeries, office visits, etc. Bills are generated due to services provided. I understand and will pay my full bills regardless of in network insurance participation.

Returned Checks & Past Due Accounts: Returned checks will be subject to collection charges, penalties, and interest. Future appointments will be refused until old balances have been paid in full. If account is not paid within 90 days of the date of service and no financial arrangements have been

made, you will be responsible for all collection agency fees in addition to your outstanding balance. For accounts sent to APEX Collections, patient will be responsible for the added collection fee of 25%.

You agree in order for our collection company to service your account or to collect monies you may owe, Turner Dermatology, PC and/or Apex Collections may contact you by telephone at any telephone number associated with your account including wireless telephone numbers, which could result in charges to you. Apex may also contact you by sending text messages or emails, using any email address you provide to use**.** Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

Minor Patients: The accompanying parent/legal guardian of the minor child will be responsible for payment at the time of service and for the minors account balance. All balances must be paid prior to patient being seen.

Blue Light/Photodynamic Therapy: If, for any reason, patient's insurance does not cover treatment, it is the patients responsibility to pay. Certain areas may be considered off-label, (such as chest, back, etc.), and even after a prior authorization is approved, your insurance may refuse to pay. In this event, it is 100% the patients responsibility to cover all costs from the Blue Light/Photodynamic Therapy treatment.

Medical Records: Medical Records will be sent out upon request in writing and a fee will be charged based upon the current charge from the Commonwealth of PA.

Requesting Forms/Letters from Providers: Any forms that a patient requests be filled out (ex: workman's comp, letters for FSA/HSA to cover treatment/product/prescriptions, etc) will be charged a $25 and up fee depending on the form/letter needing to be completed.

Products & Medications/Online Orders: All sales on products and prescriptions are final. No returns or refunds are allowed.

Cosmetic consultation with medical providers: cost of cosmetic consultation with a medical provider is $250 due at time of booking. This fee cannot be refunded or transferred to other services. If patient cancels within 48 business hours OR no-shows for appointment, patient understands they forfeit deposit and will need to pay another $250 to book another appointment time.

No Show/Late Cancellation Appointments: Patients will be charged a $50 no show/late cancellation fee for medical appointments if they do not provide 24 business hours notice and a $150 no show/late cancellation fee for surgical appointments if they do not provide 72 business hours notice prior to their appointment time for cancelling or rescheduling. A $150 no show/late cancellation fee will be charged for cosmetic appointments if patient does not give 48 business hours notice for cancelling or rescheduling (with the exception of CoolSculpting, which requires 72 business hours notice.) Please see detailed cancellation policy at TurnerDerm.com.

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I understand there are no exceptions to this policy. While Turner Dermatology does send several text message reminders prior to my appointment, a missed appointment due to failure to receive a reminder message will still be charged the appropriate fee. Repeated missed appointments may result in discharge from the practice.

Certified letter for biopsy results that need follow up: We will attempt to contact you three times in regards to your biopsy results that require a follow up. If you fail to respond (or fail to schedule your follow up) and we need to send a certified letter, you will be charged a $50 fee.

By signing this document, I guarantee payment of all charges for medical treatment and services provided to me (or my dependent) by Turner Dermatology. This includes Evaluation and Management services in addition to any Procedures that may be required during the course of my visits. I agree to all subsections and fees of the financial policy. I have read, understand, and will comply with the information contained within this Financial Policy.

Print Name: _____

Sign Name: _____

Date: _____

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