BEND DERMATOLOGY
CLINIC
DERMASPA

FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is you receive the proper and optimal treatment needed to restore and maintain your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our staff.

1. Your insurance will be filed as a courtesy to you; however you are responsible for the entire bill. **All co-payments, unmet deductibles and other patient responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

2. In the event your insurance company does not pay the claim within a reasonable amount of time (45 – 60 days) then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

3. If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit in full becomes your responsibility.

4. It is the policy of this office that the adult presenting a child/minor for treatment is responsible for payment.

5. Returned checks will be subject to a returned check fee of $25.00.

6. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.

7. **FINANCIAL AGREEMENT:** The undersigned in consideration of the services to be rendered to the patient is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.

8. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

9. Any cosmetic procedures will not be billed to insurance and the cost of the procedure will be due at the time of service. Your provider will determine if procedures are cosmetic or medically necessary.

10. A 24 hour notice is required for cancellations. A $50.00 fee for office visits and the full price for laser or cosmetic procedures will be charged if a 24 hour notice is not provided.

Methods of Treatment:

The treatment of skin conditions depends on the type and location of the growth and the symptoms you are having. Your provider will discuss the appropriate treatment options with you. The most common forms of treatment include:

Curettage is the process of scraping skin with a sharp surgical instrument to remove skin tissue.
Shaving or Tangential Excision is the horizontal removal of a lesion.
Surgical Excision involves injection of a local anesthetic followed by cutting into the skin with a surgical instrument, removing the growth, and closing the wound.
Cryosurgery is the process of destroying skin tissue by freezing it with liquid nitrogen using an aerosol spray. This is common treatment form for warts and precancerous lesions.
Laser surgery uses an intense beam of light to burn and destroy tissue.

Multiple visits for cryosurgery or laser surgery are often required. This is especially true for treatment of warts. Each visit is billed separately.

*The following charges are the most common treatment fees and are **usually applied to your deductible.***

Cryosurgery (liquid nitrogen spray)

Actinic Keratosis only
$166.00 1st lesion
$16.00 each additional lesion
$374.00 15 or more lesions

All other lesions including warts
$230.00 for 1 to 14
$274.00 for 15 or more

Biopsy
$219.00
$71.00 each additional biopsy

Pathology – ***Required for all biopsies or lesion removals***
$246.00

Your provider is required to send a biopsy or removal of a lesion to pathology. Tissue samples will be sent to Cascadia Histopathology, however if you prefer to use to a different lab we do require notice of that request at the time of service. Occasionally our providers may require a second opinion; in this case there will be a bill from both offices.

If you would like an estimate or have any questions about costs, please let the receptionist know and someone from billing will be happy to come and speak with you.

I have read and fully understand the Financial Policy and have been given the opportunity to ask questions.

_____ _____
Signature of patient, legal representative for health care services Date

If other than patient:

_____ _____
Relationship of Representative Reason individual is unable to sign, i.e. minor or legally incompetent