



ANTHONY DEE, MD, PLLC Dermatologic Center for Excellence

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FINANCIAL POLICY

(Effective 1/13/2020)

Welcome to the Dermatologic Center for Excellence. The following is a list of guidelines that defines our Practice's Financial Policy, which are necessary in order to continue to provide high-quality care and make your visits as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW

1. I authorize Anthony Dee, MD PLLC to furnish my medical information necessary to insurance carriers concerning my illness and treatments, and to process any submitted claim by the office and medical staff at Anthony Dee, MD PLLC. I do hereby assign the provider all payment for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.
 - a. Your insurance is a contract between you, your employer, and the insurance company. It is the patient's responsibility to be aware of their insurance coverage, policy provisions, authorization requirements, as well as network providers if applicable. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanations should be made to you, their policy holder. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation. Our office participates in a variety of insurance plans. Due to relationships between insurers, third party administrators and "umbrella" networks, patients are strongly advised to contact their insurance carrier for participating provider information.
 - b. If you have an insurance plan in which we do not participate, you will be **required** to sign an Out-of-Network Waiver and our office will be happy to assist you in filing the insurance claim upon request. However, payment in full is expected at the time of service and your insurance company will reimburse you accordingly.
2. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
3. If you have a change of name, address or telephone number, please notify the receptionist.
4. We will collect your co-payment, deductible deposit, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. **If you have a deductible plan we will collect \$25 for existing patients and \$50 for new patients as a down payment for your visit.** We accept cash, checks, or credit cards. **The fee for a returned check is \$25.** We will not waive or discount co-payments or deductible payments that are **required** by your health insurance carrier. **There will be a \$10 fee if not paid day of service.**
5. **For all new patients a down payment of \$50 will be required to book your visit.**
6. We require a Credit Card to be kept on file for all patients. Your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time you will be sent a statement which you will have 30 days to pay. After 30 days, if the bill remains unpaid, we will bill your credit card. Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged. If the credit card on file changes, expires, or is denied for any reason, and a new, valid card is not provided within 5 business days, a \$10 late fee will be added each month following, until the balance is paid. If you have any questions about this policy, please do not hesitate to ask.
7. **Delinquent Accounts:** If your insurance denies our charges, does not pay us in a timely manner, or if your account becomes delinquent, we reserve the right to refer your account to a collection agency and be reported to the credit bureau. **All delinquent accounts over 30 days will be subject to a monthly fee of \$10.** Patients with an outstanding balance of 120 days overdue must make arrangements for payment prior to scheduling appointments. These accounts may be turned over to a collection agency unless prior arrangements are made with our billing service. Patients will be responsible for legal/collections fees. Please remember that it is your responsibility to pay your bill in full when you are billed. We realize that there may be extraordinary circumstances which make it impossible to do so. If you are experiencing such difficulties, we may be able to make special arrangements in your case, but only if your call the office for assistance.
8. **Referrals:** Many insurance plans require a referral from your primary care physician to be seen by a specialist. To avoid delays, please bring any required referral for treatment at the time of your visit. If you do not have a required referral, your visit may be rescheduled or you will be financially responsible for the office visit and will be **required** to sign the necessary form agreeing to as such.
9. **Medicare patients:** We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due.
10. **Self-Pay Patients:** patients with no insurance, or non-participating insurances, will be expected to pay at the time of service. If you will not be able to pay in full; you must contact our billing department prior to seeing the doctor, and/or mid-level provider to make payment arrangements.
11. **Completion of Forms:** \$10 per form 1-2 pages. Forms that are more than 2 pages will be \$20 to be completed. Payment is due prior to the form being completed.
12. **Copy of Medical Records:** .75 cents per page due prior to medical records being processed and sent.
13. **Cancellations/No Shows:** We require 24 hours notice of change or cancellation of your appointment. **If you fail to show, or your appointment is changed/cancelled within 24 hours of the appointment time, there is a \$50 fee for general appointments and a \$100 fee for surgical appointments.** While we do our best to contact you two business days prior to your appointment to remind you, *this is a courtesy. Not receiving a confirmation call does not make a last minute cancellation or no show exempt.* We reserve the right to not allow new appointments to be made until previous cancellation/no show fees are paid in full. We do understand that some unexpected circumstances do occur (i.e., illness, work emergencies, delayed flights, car trouble, etc.); however, they are also out of our control – so they are not exempt from our last minute cancellation policy. If there are re-occurring no show appointments the account will be in review and may be discharged from the practice for non-compliance.

I certify that I have read and understand this financial policy.

Signature _____

Date: _____