



FEBRUARY 2022
PATIENT FINANCIAL POLICY
AGREEMENT

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Board-Certified Dermatologists

Thank you for choosing Westgate Skin & Cancer for your Dermatology needs. We aim to deliver outstanding and transparent service. It is important that patients understand their rights and responsibilities. Herein, "Westgate Skin & Cancer, PLLC" will be known as "the Practice."

PLEASE REVIEW AND INITIAL EACH POLICY

Scheduling Policy: The Practice requires a Credit Card on File (CCOF) or an on-account deposit to hold appointments. The Practice securely stores and encrypts card information, and once stored, card information cannot be retrieved.

Select One (Required)

CCOF: I understand, consent, and authorize Westgate Skin & Cancer to securely store my card on file and charge my card for any cancellation or rescheduling fees, telemed visits, or release of record requests.

Deposit: I understand, consent, and authorize Westgate Skin & Cancer to keep a \$50 deposit for consults or a \$200 deposit for advanced procedures.

Select One (Optional)

Auto Bill: I do not want to receive a paper statement. You may automatically charge the card on file for any balance under:

- \$100 \$300 \$1,000 All

Statement of Financial Responsibility and Authorization to Treat: I understand and consent that, except as defined by my health insurance, I am financially responsible for any and all charges for services rendered by the Practice. I understand that I have the right to call my insurance before care is received if I have questions. I understand that I have the right to refuse treatment for any reason including the inability to fulfill financial obligations. I authorize medical treatment and procedures to be performed on myself, or the patient listed below, at the discretion of the Practice's providers and staff.

In-Network Insurance Claims, Assignment, and Estimates: I understand that the Practice will bill all provided in-network insurance policies for medically necessary services rendered. I understand and consent to the release of information to my insurance company regarding my treatment at the Practice. I authorize assignment of insurance payments to be made directly to the Practice for all insurance benefits. I understand that the Practice will verify my eligibility and benefits with my insurance company, but verification of benefits is not a guarantee of payment or coverage.

I consent to pay at the time of service for:

- Co-Pay estimates
Deductible estimates
Co-Insurance estimates
Any other estimated out-of-pocket costs

I understand that I will be billed if:

- My insurance company pays less than what is estimated
My insurance company denies my claim
My insurance company does not pay within 90 days
My insurance company recoups payment or benefits at a later date

Self-Pay Patients and or Out-of-Network Insurance Claims: I understand that payment is due in full at the time of service. If I pay by cash, it is my responsibility to ensure that I receive a receipt for payment. I understand that elective services or packages must be purchased in full at the time of my visit and past services or procedures will not apply to the package. Packages expire 1 year from the date of purchase. I understand that I am responsible for filing out-of-network insurance claims and any insurance benefits are between myself (the patient) and my insurance company.

Practice Fees: I understand and consent to pay the following fees that are not covered by my insurance. All appointments must be cancelled or rescheduled 24 business hours in advance.

- No-Show Fee - \$50 for all medical consults, cosmetic consults, basic medical procedures, and basic cosmetic procedures
No-Show Procedure Fee - \$200 for all advanced procedures including fillers, surgeries, area laser treatments, and sclerotherapy
Returned Check Fee - \$50 in addition to any outstanding balance if my check is returned for any reason
Delinquent Account Fee - I will pay my past due balance and an additional 34% service fee if my account is sent to collections
Re-Instatement Fee - \$200 if I am dismissed from the practice, and upon approval from the medical director, reinstate my care
Release-of-Records Service Fee - \$25 for the first 500 pages, \$50 for over 500 pages for any request received with my signature

Pathology and Lab Fees: I understand and consent to be billed by an outside lab for services rendered. I understand that certain procedures, such as biopsies or cultures, require pathology and or lab services. I will make financial arrangements directly with these organizations. Fees may range between \$100 to \$400 per sample/specimen and determination of fees may not be possible until after orders are processed.

Product Purchases: I understand that the Practice has partnered with Dermly for all product purchases and product fulfillment. All product purchases are final, and should an issue arise with the product itself, the item can be exchanged for similar/like products. Additional terms and conditions are available at dermly.com/terms

SIGNATURE

I understand that my signature below confirms that I have read, understand, and consent to Westgate Skin & Cancer's Financial Policies.

Patient, Guardian, or Responsible Individual Signature

Patient Name

Date Signed