OHIO SKIN CENTER

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Agreement of Financial Responsibility

Thank you for choosing OHIO SKIN CENTER as your healthcare provider. We are committed to providing quality care and service to all of our patients. This Agreement of Financial Responsibility has been updated and will supersede other signed versions as of Sep 5, 2023.

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/provider relationship. As such, we offer the following information regarding our insurance and financial policies. All patients are expected to carefully read, sign and comply with our financial policy. A copy of this policy will be provided to you upon request.

PAYMENT AT TIME OF SERVICE: All payments (including copays, deductibles, coinsurance, cosmetic fees, and non- covered service fees) are due IN FULL AT TIME OF SERVICE. We do not bill insurance companies for cosmetic procedures. We accept cash, checks, and credit cards.

_____Initial **We require all patients with commercial insurance plans to maintain a valid credit card on file with Ohio Skin Center. Credit, debit, or HSA cards on file will be used to pay account balances after your insurance company has processed the claim. We require the credit card on file to be set at no less than $1500.00 at time of initial services. Your card will only be charged the amount due for services after insurance coverage has been processed.**

INSURANCE: As a courtesy to our patients, Ohio Skin Center will file primary and secondary insurance claims on your behalf. It is your responsibility to provide a copy of your photo ID and current valid insurance card on the date of your visit. If we are unable to verify your insurance by the time of your appointment, you will be considered “SELF PAY”. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim. Please understand that it is YOU the patient, who has a contract with your insurance carrier. It is your responsibility to understand your insurance plan coverage. As the patient (or legal guardian if the patient is a minor), payment for your healthcare is ultimately your responsibility.

CO-PAYMENTS, DEDUCTIBLES AND COINSURANCE: During your visit, you will be provided with a good faith estimate of your responsibility for any surgical procedure at your request. As this is only an estimate, after your claims have fully settled, refunds will be issued for overpayments and you will be billed for any balances. Payment will be due at time of service if your deductible has not been met or if your plan requires a coinsurance payment. Your deductible, coinsurance, and copay are your responsibility and part of the contractual agreement that you made with your insurance company. Failure on our part to collect this from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

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A **copayment** is a dollar amount set by your insurance company which you are responsible for at each visit. A **deductible** is the amount you are obligated to pay before your insurance company starts paying for your healthcare costs. Some insurance plans may also have a **coinsurance,** in which you may be responsible for a percentage of healthcare costs in addition to your copay or deductible.

Please note that certain services connected to your visit (particularly, pathology fees for biopsies/excisions and lab fees for tests sent to the laboratory) will be billed to you separately by the independent service provider; **charges for these services are not included in your office visit and procedure charges, nor your provided quote.**

Patient Statements: As of December 2023 Patient statements will no longer be mailed to your address on file. Statements can be accessed via the Patient Portal, and reminders will be sent via Email or Text message based on your information on file.

COLLECTIONS: Please note, if payment is not received from either you or your insurance company within **90 days from the date of service(s),** your account will be considered delinquent and subject to assignment of your account to a collection agency. If this occurs:

- You agree that the collection agency may contact you by mail and/or phone.

- Your account balance due will increase by 25% to cover collection agency and administrative costs.

- You will be responsible for all attorney fees and court costs associated with these collections.

RETURNED CHECKS / CREDIT CARD REVERSAL FEE: There is a $35 charge for any returned checks or credit card reversal, no exceptions.

PRIOR BALANCE: Patients with a prior balance are expected to pay any patient balance in full before any additional services are provided. If the balance cannot be paid in full, then you must speak with our Billing Department or Practice Manager to make payment arrangements prior to your appointment. If this is not done, appointments may be rescheduled.

MISSED APPOINTMENTS/ LATE CANCELLATION: Ohio Skin Center understands that schedules sometimes change. If you are unable to keep a scheduled appointment, we ask that you call us at least 24 hours in advance to reschedule. This allows us to reschedule your canceled appointments in a timely manner and allows other patients with urgent needs to quickly access our providers.

- If you cancel your appointment **less than 24 hours before your scheduled appointment,** you will be charged a cancellation fee of **$50.00**.

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- If you **do not call to cancel or reschedule before your scheduled appointment time**, it is documented as a **NO SHOW** and you will be charged a fee of **$100.00**. **Three Medical Office Visit NO SHOWS in 12 months constitutes dismissal from our practice. Two Surgical/Procedural Visit NO SHOWS in a 12 month period constitutes dismissal from our practice.**

- Patients who fail to show for their **scheduled office procedure appointment or did not notify the office within 48 hours of their scheduled appointment** shall be subject to a **NO SHOW/CANCELLATION fee of $350.00.**

_____Patient Initial

NO SHOW fees will be billed directly to you, the patient. This fee is not covered by insurance and must be paid prior to your next appointment.

PATIENT SATISFACTION AGREEMENT:

Ohio Skin Center holds your satisfaction as a top priority. We take pride in Ohio Skin Center's reputation for excellence and standing in the community, and are committed to maintaining that standing every day. As we agree to work as hard as we can to meet your satisfaction, you agree to report to us any question or concern you have in relation to the care we have provided. You agree to provide Ohio Skin Center 30 days from communication to our team of your concern to investigate and address the matter. You agree if after 30 days you feel that your concern was not addressed adequately that you provide Ohio Skin Center with a written copy of any communication you plan to disseminate regarding the issue prior to doing so. You further agree that failure to follow this policy entitles Ohio Skin Center to equitable relief.

AGREEMENT TO OFFICE AND FINANCIAL POLICY:

I have read the above office and financial policies and understand my responsibilities as a patient at Ohio Skin Center. I understand that I will be expected to pay for all applicable co-pay, deductible, coinsurances and cosmetic/non-covered services on the day of service. I agree to the Missed Appointments/Cancellation appointment policy and charges according to the missed appointment fee schedule outlined above. I understand that failure to make payment when due is the basis for legal action and agree to pay all costs of collection, including, without limitations, reasonable attorney fees, legal and other court costs, collections charges, fees and expenses and interest. I understand that Ohio Skin requires all patients with commercial insurance plans to maintain a valid

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credit card on file with Ohio Skin Center. Credit, debit, or HSA cards on file will be used to pay account balances after your insurance company has processed the claim.

By signing this document, I am agreeing to the terms of Ohio Skin Center's Office and Financial Policy.

_____ _____

Printed Name (Patient/Parent or Legal Guardian) Date

_____ _____

Signature (Patient/Parent or Legal Guardian) Relationship to Patient