matherne
DERMATOLOGY + AESTHETICS

BILLING POLICY

Patient Name: _____ **Patient DOB:** _____

- In-Network Patients: All deductibles, co-payments/co-insurance, and or other payments are due at the time of service. Pre-certification does not guarantee benefits or eligibility. As a clinical provider contracted with your insurance company, Matherne Dermatology will take the responsibility of filing your charges directly to your insurance company. Some services required for your treatment may be denied by your insurance company secondary to plan, medical necessity, or other policy limitations. We will attempt to re-file a denied claim on your behalf one time. If your claim is denied again, you are responsible for payment in full of all services denied or not covered by your insurance.
- Out-of-Network Patients: Payment is due in full at time of service.
- Co-payments and Deductibles: All co-payments and/or percentage of deductibles will be collected at the time of service. All patients are responsible for timely payment of any balance.
- Payments: Payments for services can be paid by cash, check, money order, credit/debit card, or Care Credit. Checks must be made payable to Matherne Dermatology. All charges associated with the collection of this bill become the responsibility of the patient and or responsible parties.
- NSF Checks: Any form of payment returned to Matherne Dermatology as NSF will be assessed a $25 service fee.
- Past Due Accounts: If your account if 60 days past due, you will not be allowed to schedule an appointment until payment has been made.
- Cosmetic Procedures: Payment for a cosmetic procedure and or products are due at the time of service.
- Attorney Cases: Should an attorney be involved in the billing process, please be aware that we do not accept "letters of guarantee" from attorneys and all payments being made by attorneys must be paid as services are rendered. Should the outcome of the case not be in your favor and the attorney does not pay the bill, the patient/responsible parties will assume full responsibility for payment for all services rendered.
- There may be an additional charge from an outside laboratory for histopathology services.
- I authorize Dr. Matherne to evaluate and treat my medical condition. I authorize the release of medical information as needed to my referring physician, consultants, and insurance carrier to process insurance claims, applications and prescriptions. I also authorize payment of medical benefits to the physician.
- I will notify Matherne Dermatology if/when there are any changes in insurance carriers and/or contact information.

By signing this agreement, I understand and agree that I am responsible for the balance on my account for any professional services rendered. I have read and understand the information presented and I agree to the above policy and procedures.

_____ _____

Print and signature of patient (if over 18) Date

_____ _____

Print and signature of guarantor (if patient is under 18) Relationship to patient