INFORMATION REGARDING INSURANCE AND BILLING

1. It is your responsibility to understand your insurance benefits. If you are not sure if a service or treatment is covered you should contact your insurance carrier. We do not provide information about copayments, coinsurance, or deductibles. If your insurance card indicates you have a copayment, that amount is requested at the time you check-in. If there is an additional balance due you will receive a bill from us.
2. Your copayment or coinsurance is required when you check-in. You are also responsible for payment of your deductible. We will accept your payment in cash, check, Visa, Mastercard, or American Express.
3. There is a $35.00 fee for returned checks.
4. 18% per annum interest may be applied to delinquent accounts. Delinquent accounts may be placed with an outside collection agency or pursued through small claims court. You will be responsible for court costs, attorney fees, and/or collection agency fees.
5. We accept many insurance plans. This means we will file your claim for you. This service is provided as a courtesy to you because we value your patronage. **You are responsible for charges not paid by your insurance carrier(s), which includes denied claims due to lack of information from the subscriber.**
6. We will be happy to submit charges to any secondary or supplemental plans you may have, however, if payment is not received from that firm within 60 days we will issue a bill to you for payment in full.
7. If we do not accept your insurance plan, payment will be expected when services are rendered. You will be given a bill at time of checkout, which you may file with your insurance carrier for reimbursement.
8. If for any reason we do not receive the anticipated payment from your insurance company, please understand you are responsible for treatment fees.
9. All insured patients must present their insurance identification card at the time of check-in. If you do not have your insurance identification card and a photo ID you will be asked to pay for your office visit or reschedule to another date.
10. It is your responsibility to provide accurate insurance information to this office. If we are unable to bill your insurance carrier because we did not receive your insurance information in a timely manner, you are responsible for the charges.
11. All surgical removals are sent for pathology testing. Additional laboratory charges will be incurred for this testing.
12. Cosmetic and medically unnecessary procedures are not covered by insurance. You will be advised if your teatment is considered such a procedure and how much it will cost before proceeding. Payment is requred at time of service.
13. If your insurance plan requires you to be referred to a dermatologist, you must obtain this referral from your primary care physician *before* coming to our office. You may phone our office the day before your appointment to see if we have received your referral. If you do not have an appropriate referral at the time of your appointment, you will be given the choice of rescheduling your appointment or paying for your visit.
14. The fees we are paid by insurance carriers for office visits, surgery, pathology and related services are based on Medicare fees and closely followed by the insurance companies. We do not set any insurance company's fee schedule and we must operate our business within the confines of this structured fee schedule.
15. We appreciate a 24-hour notice to cancel or reschedule any surgery appointments. A $100.00 no-show or late cancellation fee may be assessed if advance notice is not provided. A $50.00 deposit is required for any planned surgeries. This will be collected when you check in for surgery. Any overpayment will be refunded once the charges are paid by insurance.
16. Any questions regarding your account should be addressed to the Billing Department at (615) 893-4705.

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies. I understand I am responsible for all charges not paid by insurance. A photocopy of this document is as valid as the original. You may receive a copy of this document upon request.

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Patient (or Guardian) Signature Date