COAST
DERMATOLOGY
& SKIN CANCER CENTER
J. Gregory Neily, DO

OFFICE FINANCIAL POLICY

Patient Name:_____ **Date of Birth:**_____

Dear Patient:

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Medicare Recipients:
We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:

a. The annual deductible
b. Co-payments
c. Charges for non-covered or cosmetic services*

* You will be asked to sign an Advanced Beneficiary Notice in the event that a service is provided which we know is not covered by Medicare.

If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we do not participate, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60(sixty) days after we file a claim, you will be sent a bill and will be responsible for the balance within 10 days after receipt.

Non-Medicare/Commercial Plans:
If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all covered, medically necessary services. At the time of service, you will be responsible for the payment of:

a. The annual deductible
b. Co-payments
c. Charges for non-covered or cosmetic services.

In the event that you, as the patient, or we, as the provider, are not aware of a charge that is not covered by your plan, you will be balanced billed after we obtain a denial from your insurance carrier.

For non-Medicare patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:

As a courtesy to you we will file your insurance for you. If we do not receive payment from your insurance company within 45 days of filing, you will be billed for the entire amount. Payment will be due within 10 days of receipt of the statement.

It is your responsibility to make the staff aware of any changes in your insurance coverage.

Under normal circumstance we do not provide the option for a "Payment Plan." However, for those patients who are not insured we do provide reduced rates based on your financial situation.

If you have an HMO or any insurance that requires a referral from your primary care doctor or prior authorization it will be your responsibility to make sure this has been done prior to services rendered.

By signing below I understand the Office Financial Policy as stated above and agree with the terms.

_____ _____
Patient Signature Date

_____ _____
Patient Guarantor (if other than patient) Date