REN
DERMATOLOGY

FINANCIAL POLICY

Thank you for choosing REN Dermatology for your dermatologic needs. Our physicians and staff are committed to delivering quality care and service to you. Understanding our financial policy is an important part of our professional relationship. Below is an explanation of our payment, cancellation, and no-show policies. Please make yourself aware of these policies as you sign off on them.

IN NETWORK INSURANCE:

REN Dermatology participates in most major insurance plans. To ensure that REN Dermatology is in network with your insurance, please contact your insurance carrier. It is your responsibility to provide REN Dermatology with accurate, up-to-date insurance information.

- REN Dermatology is current in network with United Healthcare, Medicare, Cigna (with the exception Connect/EPO Network), Aetna, Humana, Blue Cross Blue Shield, BCBS Medicare Advantage, and Humana Medicare plans.
- At this time, REN Dermatology cannot see Oscar, Medicaid, or PHCS/Multiplan patient including but not limited to: Amerigroup, TennCare, CoverKids, United Healthcare Community Plan, and Blue Care.

COPAYMENTS, DEDUCTIBLES, AND COINSURANCE

Your insurance co-payment is due at the time of your visit. Skin biopsies and pathology services performed in-house will be charged along with the office visit. If further testing is required to obtain an accurate diagnosis, your specimen will be sent to an outside laboratory where additional charges may apply. If you are unable to pay your co-payment at the time of your visit, we will reschedule your office visit. If we determine that you have a deductible or a co-insurance amount due, you will be asked to pay this amount at the time of your visit. We do our best to have accurate collections, but please note that your co-pay/deductible are subject to determination by your insurance company. As a courtesy, our officer will file your claim with your insurance company and initiate correspondence with the purpose of getting you the maximum coverage your insurance allows.

SELF PAY FEE SCHEDULE:

REN Dermatology is out of network with certain insurance providers. It remains the responsibility of the patient/policy holder to know your insurance coverage, including out of network benefits. REN Dermatology does not file out of network benefits. REN Dermatology has a flat fee schedule for out of network patients. These fees are subject to change without notice. REN Dermatology will provide information regarding the fees upon request. If you have not provided medical insurance, you hereby confirm that you do not have insurance to be billed and understand that payment is due at the time of service.

REFERRALS:

If your insurance carrier requires you to obtain a referral from your primary care physician to see a specialist such as a dermatologist, it is your responsibility to bring this with you to your visit. Referrals and/or authorizations are not a guarantee of payment. You are responsible for any balances classified as "Patient Responsibility" by your insurance company. Any dispute with claim processing is between you and your insurance company. If you do not have a referral and your insurance requires one, we will reschedule your appointment until you obtain one or you will be responsible for the self-pay rate.

AUTOPAY:

REN Dermatology encourages patients to enroll in automatic payment when insurance claims are being filed. *AutoPay* helps reduce the amount of paper statements sent. *AutoPay* is designed to be used only for insurance submitted claims after insurance has been fully processed. Patients will authorize a waiver in-office and provide the credit card to be utilized for *AutoPay*. After a claim for services rendered has been submitted and fully processed by your insurance company, any balances listed as "Patient Responsibility" will be charged to the card on file. Patients will receive an email 10 days prior notifying them of the balance to be charged, with a maximum of 1 successful payment via *AutoPay* per claim and a maximum of $250 per patient. *AutoPay* will not run again to process any residual balance. Any additional balance over $250 will be collected by REN Dermatology. If the payment fails or declines, the *AutoPay* status will be declined. The transaction will try and process for 4 consecutive business days. If still unsuccessful, the *AutoPay* claim will remain in declined status and you will receive a statement in the mail.

INSURANCE BALANCES:

REN Dermatology will submit claims to in-network insurances on behalf of the patient as a courtesy. If we do not receive payment or resolution from your insurance company within 60 days of filing the claim, the balance becomes your responsibility. REN dermatology will automatically run the credit card on file after sending an email with the amount to be charged 10 days prior to charging the card.

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APPOINTMENT CANCELLATIONS AND NO-SHOWS:

We understand that situations arise in which you must cancel your appointment. It is required that if you must cancel your appointment, you provide 24 hours' notice. Providing advanced notice is not only a courtesy to your provider but also provides opportunity for another patient to be seen. Without notification, you are subject to a late cancellation fee or a no-show fee. These fees are the sole responsibility of the patient and will be paid using the credit card on file. We understand that special unavoidable circumstances may cause you to cancel with the 24 hours prior to your appointment. Fees in this instance may be waived, but only with management approval. If you arrive 15 minutes late for your scheduled appointment time, we may ask you to reschedule for another time.

________ (initial) I understand that **standard medical appointments** which are cancelled with LESS THAN 24 HOURS notice are subject to a **$50.00** LATE cancellation fee.

________ (initial) I understand that procedure or extended appointments **(scheduled for 30 minutes or more)** which are cancelled with LESS THAN 48 HOURS notice are subject to a **$100.00** LATE cancellation fee.

________ (initial) I understand that **if I do not call to cancel my appointment AND fail to arrive to a standard medical appointment,** I will be charged a **$100.00 *No Show fee.*** If I fail to arrive to a **procedure or extended appointment time AND fail to call to cancel**, I will incur a **$200 *No Show fee.***

CHARGEBACKS AND RETURNED CHECK FEES:

There will be a $25.00 fee in addition to the original amount owed if your check is returned from the bank or your credit card charge is charged back to REN Dermatology.

________ (initial) I understand that a **$25.00** fee will be incurred for returned checks and credit card chargebacks.

PAST DUE BALANCES:

Past account balances must be settled prior to being seen for a subsequent appointment.

________ (initial) I understand that past due balances must be paid prior to being seen for a subsequent appointment.

GUARANTOR INFORMATION AND PAYMENT FOR PATIENTS UNDER AGE 18:

Guarantor information is responsible party information. A guarantor (or responsible party) is the person held accountable for the patient's bill and services rendered. A patient presenting for care that is 18 years of age or older is always the guarantor for bills relating to their care except in an incapacitated adult. College students 18 years of age or older are always the guarantor for the services they receive.
REN Dermatology does not bill absent parents for payments due at the time of service. The adult presenting the minor for care in the responsible party and guarantor.

NOTE: If the parent presenting the minor brings a divorce decree stating that the other parent is financially responsible for the child's medical bills, the guarantor is changed to the parent designated in the divorce decree. The financially responsible parent's information is required before the patient can be treated, including full name, billing address, phone number, email address, and phone number.

Guarantor name: ____

Relationship to patient: ______________________________ **DOB**: ________/________/________

☐ **Mailing address same as patient**

Mailing Address, if different than patient:

Street Name: ______________________________ **City**: ______________________________

State: ______________________________ **Zip**: ______________________________

Email Address: ______________________________ **Phone Number**: ___________/___________/___________

I certify that I have read the financial policies of REN Dermatology and I agree to abide by these policies.

Signature: ______________________________ **Today's Date:** ___________/___________/___________
(Patient or Parent/Guardian)