SPECTRUM
DERMATOLOGY OF SEATTLE

FINANCIAL POLICY

Today's Date _____

Thank you for choosing Spectrum Dermatology of Seattle for your care. We are committed to providing you with the highest quality medical care, and transparent billing practices. As patients are ultimately responsible for all charges associated with their medical care, even with insurance in place, we hope you find the following information helpful.

Patients with Insurance: We can bill most insurance carriers for you, both primary and secondary. However, this is not a guarantee of payment, therefore it is important for you to be aware of your insurance coverage, benefits, and limitations. We will bill your insurance carrier; however, you are responsible for the full charges of your visit. Your insurance policy is a contract between you and your insurance carrier. Since we are not party to that contract, you are responsible for understanding how your insurance works (For example: Is a referral required for your visit with Spectrum Dermatology of Seattle? How much is left to pay on your deductible?). We do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care. If your insurance carrier declines a claim due to inaccurate or incomplete information you have provided to us or to them, we may still bill you directly for the unpaid balances. We are not obligated to wait for you to resolve a dispute with your insurance carrier before seeking payment from you. As a courtesy, we will help you as best we can to get proper and timely payment from your insurance carrier.

Your provided signature authorizes payment of medical benefits to Spectrum Dermatology of Seattle for any services furnished by providers of Spectrum Dermatology of Seattle. You authorize the physician and clinic to release any information to process insurance claims. This authorization is in effect indefinitely until revoked in writing.

Medical insurance claims: Once your insurance has processed our claim, they will send an Explanation of Benefits (EOB) to both you and our office, showing what your total patient responsibility is. You typically receive the EOB before we do, so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier immediately.

In Network Coverage: If we have a contract with your insurance carrier, then the maximum financial responsibility (cost of your visit) for you and your insurance carrier combined is determined by our contract with them and is called the "allowable fee" for the services rendered. Your copayment is due at the time of your visit. Once your insurance carrier processes your claim, we will bill you for the remaining balance.

Out of Network Coverage: If we do not have a contract with your insurance carrier, then the maximum financial responsibility (cost of your visit) is determined by Spectrum Dermatology of Seattle prices for the services rendered. Your copayment is due at the time of your visit. We will attempt to bill your insurance carrier for the balance. Your insurance carrier will reimburse at an out-of-network provider rate. It is your responsibility to make sure you have out-of-network benefits. Your remaining balance may be higher than a balance for the same services provided by an in-network provider. The remaining balance is your responsibility to pay.

Minor Patients: A parent or legal guardian must accompany minors at the time of the initial visit, and this person becomes the party responsible. Unaccompanied minors at subsequent visits are still expected to make copayments and update patient and insurance information as needed. If parents are separated or divorced, and the parents share financial responsibility for the minor, then accurate information and signed consents from both parents are required. In the event of any disputes, the parent or guardian who accompanied the minor at the initial visit is the party responsible for all balances.

Medicare Patients: We bill Medicare for you. To do this, we must have your signature on file. We also bill Medicare Supplements and secondary insurance carriers for you. Your co-payment is due at the time of your visit.

Non-covered Services: Cosmetic services cannot be submitted to insurance. Some insurance carriers deem certain procedures as cosmetic, such as removal of skin tags and other benign growths. It is your responsibility to understand your benefits. Please see separate Notice of Cosmetic Dermatology Non-Covered Services and Self Pay Waiver.

Private/Self-Pay Patients: Private pay/uninsured patients are required to pay a $275 deposit prior to the visit. Payment arrangements must be made for any additional services. Procedures, biopsies, and laboratory testing will incur separate fees as determined by Spectrum Dermatology of Seattle and outside laboratories we collaborate with, respectively. We do not set, nor do we have access to, the prices for services provided by outside laboratories.

Missed Appointments/Cancellations: If you no-show or cancel/reschedule an appointment without 48-hour notice, the following fees will apply:

Medical Appointment Type	Fee
Office Visit	$100
Surgery	$200
Cosmetic Appointment Type	Fee
Consult	$200
Cosmetic procedure (single Tx only)	$200
Injectable (i.e., Botox or Filler)	$200
Laser Tx part of package	Forfeit single treatment count of package
Other cosmetic procedure part of package (e.g., PDO thread, Microneedling, PRP)	Forfeit single treatment of package

Returned Checks/Insufficient Funds Fee: If any payment (for example, a check) is returned due to insufficient funds, there will be a $50 fee.

As part of our Financial Policy, prior to receiving service, we require that you provide a credit card on file with our office.

How your credit card information will be secured and utilized: Upon registration, you will be asked to provide our office with your preferred payment card. We will store your payment information in our HIPAA compliant, secure software for future transactions. Office personnel will not have access to your card information. For your protection, only the last 4 digits of your card will show in our system.

Late Fees & Interest on Past-Due Balances

To ensure timely payment for medical services rendered, our office has established the following financial policy regarding overdue balances, in compliance with Washington state laws:

Days Past Due	Late Fee Amount	Interest Fee %
31	$0	N/A
61	$15	Interest will also accrue at an annual rate of 9%, compounded daily.
61	$15	Interest will continue to accrue daily until the balance is paid in full.
121	$15	Interest will continue to accrue daily until the balance is paid in full.
151	$15	Accounts with continued non-payment may be subject to further collection efforts, including referral to a collection agency. Additional fees may apply.

Medicare Patients Only: This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require if for the proper consideration of a claim. PLEASE READ AND INITIAL THE FOLLOWING STATEMENT:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to either myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. _____ (Your Initials)

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare carrier automatically "crosses over." PLEASE READ AND INTIAL THE FOLLOWING STATEMENT:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services. _____ (Your Initials)

CREDIT CARD AUTHORIZATION

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other:

Cardholder Name (as shown on card):

Last 4 digits of Card Number:

Expiration Date (mm/yy):

Cardholder ZIP Code (from credit card billing address):

I, _____, authorize Spectrum Dermatology of Seattle to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Signature: _____ Date: _____