



OFFICE POLICIES

MINORS:

Patients under the age of eighteen (18) are required to have a legal guardian accompany them to ALL office visits. Each patient has an individual account at this office. In the case of divorce or separation, the party/parties responsible for the account prior to the separation will remain responsible for the account. After a divorce or separation, the parent authorizing treatment for a minor will be the responsible party for all charges incurred during that office visit. If the divorce decree requires the other parent to pay part/all of the costs, it is the authorizing parent's responsibility to collect monies from that parent.

INSURANCE/BILLING:

Co-pays, deductibles, co-insurance and previous balances are due at the time of your office visit. Private pay patients are expected to pay in full at the time of all office visits. If you have any questions regarding your bill, please ask our receptionists or billing department about our payment plans or financial assistance.

Balances not paid in full within thirty (30) days will be considered delinquent and we reserve the right to transfer the account to our in-house collection department or a third-party collection agency (this may affect your credit score). If your account is turned over to collections, you will need to contact Evergreen Financial Services at (509) 943-2224 to make payment arrangements before you are seen at our office again.

Our office will courtesy bill most insurance companies even if we are not a contracted provider. Insurances that will not be courtesy billed include: Any state insurance, DSHS (Washington State Department of Social & Health Services), Community Health Plan of Washington, Care of Oregon or Columbia Community Care.

If you are currently in a "home health episode" and have any lab work done at our office, you may be personally responsible for charges. This office processes all biopsy specimens in-house through a CLIA certified histology lab. The slides are read and signed by Dr. Robert Hopp, who is a board-certified dermatologist with over forty years of dermatopathology experience. Occasionally, these specimens are sent to a third-party for a second opinion. There is a separate charge generated for this review that is billed the consulting provider.

STANDARD OF CARE

It is the standard of care for the office to record the patient visit, photograph important skin finding, and to update the patient's medications from their pharmacy. This information will only be kept in the patient's clinical file where it is protected by HIPPA regulations.

INITIALS: _____

POSSIBLE FEES:

This office reserves the right to add the following charges:

- Returned checks will be charged a \$29.00 fee
- Stop payment requests for misplaced refund checks will be subject to a \$35.00 fee (will be deducted from the total balance if a new refund check has to be issued).
- Failure to give 24 hours cancellation notice for your appointment will result in a \$40.00 fee (Please note: If you are ten (10) or more minutes late to your appointment, this is considered a missed appointment and you may be charged a \$40.00 fee. You may be asked to reschedule.)
- Co-pays not paid at the time of service will result in a \$15.00 fee (in addition to your co-pay)
- Some cosmetic appointments require a \$100.00 deposit. This deposit is non-refundable if you fail to give 24 hours notice to cancel your appointment or if you miss your appointment.

POTENTIAL COMPLICATIONS:

There are potential complications with any medical procedure. Common office procedures include: liquid nitrogen, triamcinolone injections, cantharone application, skin biopsy, skin excision, Moh's surgery and light therapy. Potential complications include:

- Bleeding - Scarring - Skin discoloration - Infection - Allergic reaction - Pain

Please read this agreement in its entirety and notify our staff if you have any questions before signing. You may ask for a copy of these policies from the receptionist. We reserve the right to change our policies at any time.

I hereby give my express, written consent to Center for Excellence in Dermatology PLLC and any of its agents, successors or assignees acting on its behalf to communicate with me regarding my account(s) through various means of communication, including, but not limited to: 1) any cellular telephone number; 2) any landline telephone number; 3) any text or other similar electronic number that I provide. This express consent is given in order to permit Center for Excellence in Dermatology PLLC to more easily communicate with me regarding any issue, including for the purposes of billing, insurance and collection of any outstanding balances.

PRINT PATIENT NAME: _____ DATE: _____

SIGNATURE (if patient is a minor, parent or guardian 's signature):
