California Dermatology Care

Office Financial Policy

San Ramon Location: 2262 Camino Ramon, San Ramon, CA 94583 Tel: 925-328-0255
Hercules Location: 500 Alfred Nobel Dr, Ste 185, Hercules, CA 94547 Tel: 510-669-5700

Thank you for choosing our practice! As we promise to do our best to assist you in the best way we can with your medical/cosmetic needs, we would like to delineate how financial responsibilities are delegated and fulfilled in our office. Please read the policies we have set up to ensure that your correspondence with our office is efficient and without confusion. Please initial to ensure that you read, understand, and will comply with our financial policies.

Please initial to designate your agreement and understanding of the following information.

Financial Policy Overview

1. **Insurance Coverage:** We accept insurance plans that we are in network with in accordance with our contract with individual insurance plans which encompass most PPO insurance plans, Medicare, as well as some HMO plans including; Brown and Tolland, Bay Valley, Affinity, John Muir Medical Group, and Sutter East Bay Medical Group. If you are not insured by a plan we are in network with, or do not have updated/current insurance, our office offers a **Self-Pay option** for patients to pay for their office fees until insurance is verified, or simply as another option of payment for our services.
   - **a.** While we do have a billing department to assist you with understanding any bills you may receive from our office, **it is your responsibility to know your insurance coverage and benefits including co-pay, deductible, and coinsurance.** If you have questions about what services may be covered by insurance, please contact your insurance company prior to your appointment so there is no confusion once you arrive.
   - **b.** To assure you the best quality of care from our billing department, we must keep record of your current insurance card on file. **It is your responsibility to keep our office updated when insurance is updated yearly or changed** so we always have current proof of insurance on file. If our office does not have proof of your current insurance in a timely manner, you will be responsible for the balance of any claims/services charged in that period.
   - **c.** We bill your insurance company directly; however, please be aware of the balance of your claim, coinsurance, and deductible as they are your responsibility to pay, regardless of whether your insurance company covers your claim. We allot 45 days for insurance companies to pay the claims billed by our office. If the insurance, for whatever reason, does not cover the charge, the balance will automatically be billed to you.
   - **d.** To remain financially efficient, our office sends our patients monthly to collections statements to ensure your understanding of claims billed and of the payment left as your responsibility. As it applies to unpaid account balances, if your account is repeatedly ignored, the balance will be sent.
   - e. **HMO & STUDENT PLANS**: IN ORDER FOR US TO BILL YOUR HMO PLAN FOR TODAY'S VISIT, WE NEED A COPY OF YOUR AUTHORIZATION / REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN. IF YOUR PRIMARY CARE PHYSICIAN HAS NOT PROVIDED THIS INFORMATION, WE WILL BE HAPPY TO EITHER RE-SCHEDULE YOUR VISIT TODAY OR YOU COULD BE SEEN AS A "SELF-PAY" PATIENT. KINDLY NOTE THAT A "SELF-PAY" VISIT IS NOT BILLABLE TO YOUR HMO PLAN. X __________
2. **Co-Payment, Coinsurance, and Deductibles:** If you are responsible for a co-payment, this will be collected by the front office upon checking in for your appointment in our office. Should you fail to make the required co-payment on the day of your office visit, a $20.00 additional administrative surcharge will be applied to your account. If you have a coinsurance, please notify our office and give us the necessary information to keep this on your account with your primary insurance so the billing process can move smoothly and efficiently. If you have met your deductible for the year or do not understand the leftover responsibility you have towards your deductible, please contact your insurance company to understand this prior to your visit with us.
   - **a. Please note that the co-payment for this office can be found on your insurance card next to the co-payment delegated to a specialist office.**
   - **b.** For patients who are utilizing our Patch Allergy Tests, please note that since this takes **3** separate medical appointments, the patient is responsible for paying their co-payment **at each visit**.
   - **c.** For patients who are utilizing procedures such as Phototherapy (NBUVB), Radiation Treatment (SRT), or Excimer Laser, your insurance carrier may require co-payment. X __________
3. **Self-Pay and Cosmetic Services:** If you do not have current medical insurance, or are being seen by our office for cosmetic reasons, please note that these services must be paid for on the date of service and are documented as Self-Pay and cannot be billed. If you are unsure of whether or not the service you are requesting is medical or cosmetic, please ask the office staff, as we are more than happy to help you understand.
   - **a.** For self-pay patients, the first office visit will be charged as $140 new patient consultation and every office visit following will be charged as a $100 follow-up visit. **These prices do not include any additional medical/cosmetic procedures done in office.**
   - **b.** Flexible spending accounts (HSA/FSA) may be used to pay for cosmetic or non-covered, medically related services depending on your policy. **If you are unsure of the balance left on your FSA/HSA account or how to obtain one, please contact your Human Resources Department or the designated Benefits Administrator's Office**.

c. Care Credit is also an option for the payment of services provided in this office that you may make use of to take care of your balance; however, you must present your photo ID and CareCredit card.

d. Should you choose to participate in a cosmetic procedure here in the office, **we require a 50% deposit prior to your procedure** to ensure your time slot and provider availability. Prepayments are non-refundable; however, should you choose not to go through with the procedure and give our office appropriate notice, this payment can be used as credit on your account and be applied to other purchases. X __________

4. **Late/Missed Appointments and Cancellations:** As a courtesy, our clinic sends out text/phone/email reminders prior to your appointment date. To cancel or request a change to an existing appointment, you have the option of calling, emailing, or sending us a message via your patient online portal 24 hours prior to your appointment. **To provide timely service to you, please observe the following policy:**
   - **Late Arrival Policy: If you are 15 minutes late for your cosmetic services appointment, you may be asked to either receive a shortened treatment or to reschedule your appointment to a different time. All appointments that are arriving 15 minutes or later will be asked to reschedule (late cancelation/no show policy applies).**
   - **Late cancelation/no show policy: We reserve the appointment schedules for patients that need the service. Should there be a no show or late cancellation for medical appointment, without 24-hour notice, an additional charge of $50 will be billed on your account; a $150 additional charge will be billed, should you miss a surgery or cosmetic procedure, without calling the office 24 hours in advance.** X ______
5. **Refund Policy:** Given the circumstance that a product or prepayment is approved for refund, there will be a 5% processing/administrative fee, taken out of your total refund. Please be aware that refunds in the form of credit card or check take 7 business days to be processed.
   a. **Skin Care products that are unused or used but caused irritation, may be returned within 30 days of purchase** with a 5% restocking fee upon refund, or exchanged with another product.
   b. **Prescription medication may not be refunded or exchanged, per federal and California state regulations.** X __________
6. **General Payment Policy: We accept Visa, Master, Discovery, American Express, CareCredit, and Checks only.** If you choose to pay with check, and a check is returned to our office for insufficient funds, or if a payment has been halted before our office has processed it, there will be an additional $50 charge for office inconvenience. It should also be noted that all Self-Pay services must be paid on the day of service and cannot be billed at another time. X__________
7. **Health Form**: Fees are required as follows: disability form and school/work physical exam paperwork $100; medical record requested for life insurance or by attorney office $75. X__________

Should concerns and questions arise regarding your insurance billing or any financial correspondence with our office, you may call our billing department at (925) 328-0220 Monday - Friday from 8:00 am - 5:00 pm.

Office Policies *Please initial the following to show that you will comply with our office policies.*

1. This practice does not allow patients or family members to take photographs or audio/video recordings any parts of our office/ staff or patients without explicit pre-approval and written consent from the office.
2. The office is not responsible for childcare or unsupervised children during clinic hours; please be mindful that this is a medical office and make sure that all children are supervised.
3. Please keep your personal belong or valuables with you at all time. Should you lose a personal item in our office, we do have a lost and found drawer designated to lost items; however, we will not be held responsible if something is lost in our office.

X __________

Office Consents *Please initial to designate your consent.*

1. I consent, that Dr. Ting and the office may communicate with another medical care provider when it is medically appropriate as part of the effort to better coordinate my medical care and ensure that I receive the best treatment. X __________
2. I have read the **HIPAA Notice of Privacy** and understand the information contained by this document. X __________
3. I consent to receive automated messages from the appointment calling system via email, phone and/or text *(circle All that apply)* to remind me of my appointment.
   a. Phone: (_______) ________ - ______________
   b. Email: ____
   c. I consent (yes/no) to leave a message regarding my visit to the phone/email same as above or:
   Phone: ______________________/ Email: ______________________
   d. I consent that the office may discuss my visit or diagnosis/treatment with (please circle) only myself or the indicated individual(s) ______________________ X__________

I have read and understand the financial and office policies written, and agree to abide by its guidelines.

______________________________ ______________________

Signature of Patient or Responsible Party **Date**