California Dermatology Care

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
Livermore Location: 48 Fenton Street, Livermore, CA 94550 Tel: 925-359-6255

Office Financial Policy

1. **Insurance Coverage:** We accept insurance plans that we are in network within 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 of the best quality of care from our billing department, we must keep the 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 FOR 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 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, an additional $20.00 administrative surcharge will be applied to your account. If you have 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. (Please initial after reading through carefully the following a, b, c, d) X _____
    - **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 **on 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.
    - **d.** Office will pre-collect patient's PPOA (patient's out of pocket portion) that will go into deductible and coinsurance prior to procedure.
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 whether the service you request is medical or cosmetics, please ask the office staff, as we are more than happy to help you understand.
    - **a.** For self-pay patients, the new office visit* will be charged $340/200 for MD/PA for new patient consultation and every office visit will be charged as a $280/$160 follow-up visit with MD/PA respectively. **These prices do not include any additional medical/cosmetic procedures done in the office.** *The new office visit rate applies to patients who haven't been seen for 3 years or more since the last visit. X_____
    - **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**. X_____
    - **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. X_____
    - **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. **Any refill of topical prescriptions beyond 6 months of last office visit or oral/systemic prescriptions including biologics beyond 3 months will require either in person or virtual follow up evaluation for requisite documentation for medical necessity. X_____**
5. **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:**

   a. Late Arrival Policy: If you are 15 minutes late for your cosmetic services appointment, you may be asked to either receive shortened treatment or to reschedule your appointment to a different time. All appointments that arrive 15 minutes or later will be asked to reschedule (late cancelation/no show policy applies). X_____

   b. Late cancelation/no show policy: We reserve the appointment schedules for patients that need the service. Should there be no show or late cancellation for the medical appointment, without 24-hour notice, an additional charge of $50 will be billed on your account; an additional $150 charge will be billed, should you miss surgery or cosmetic procedure, without calling the office 24 hours in advance. X _____
6. **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 checks take 7 business days to be processed.

   A. Skin Care Products that are unused or used but cause irritation may be returned within 30 days of purchase with a 5% restocking fee upon refund or exchange with another product. X_____

   B. Prescription medications may not be refunded or exchanged, according to federal and California state regulations. X _____
7. **General Payment Policy**: We accept Visa, Master, Discovery, American Express, CareCredit, and Checks only. Debit cards will be processed as credit cards based on the logo on the cards. If you request a credit card change for a payment that has been settled with another credit card or if the card was declined or charged back by the bank, there will be 5% of the credit card processing charge. If you choose to pay by cheque, 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_____
8. **Credit Card on File Policy:** To streamline billing and ensure accurate account management**,** our office requires a valid credit card to be kept securely on file. Your card will only be charged for patient balances after insurance payments have been processed and applied and the outstanding balance from cosmetic/self-pay service and product purchases. You will receive a statement or notification prior to any charge. All credit card information is stored securely in compliance with PCI standards. If you have any questions about this policy, please contact our billing team. X_____
9. **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_____
10. I am informed that the Open Payments database is a federal tool used to search for payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. X_____
11. Minor or young adult patients aged 25 and below: At least one parent will be required as payment guarantor for all visits that have any out-of-pocket expenses incur. X_____
12. For Minor patients, I authorize Medical Treatment of Minor Child. 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 of any parts of our office/ staff or patients before, during and after the office visit while on the office premises without explicit pre-approval and written consent from the office. X_____
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. X _____
3. Please always keep your personal belongings or valuables with you. 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 your consent.*

1. I agree 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 their guidelines.

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Signature of Patient or Responsible Party **Date**