Metrolina Dermatology
and Skin Surgery Specialists

Notice of Privacy Practices, Financial and Cancellation Policies

Date: _____

Full Name: _____ **DOB:** _____

Thank you for choosing Metrolina Dermatology. At Metrolina Dermatology, we are committed to providing exceptional care and ensuring appointment availability for all patients. To support this goal, we have established a no-show and late cancellation policy for our patients. We have a credit card on file policy which helps ensure timely resolution of patient balances, reduces administrative delays, and allows our team to stay focused on what matters most, your care. Please review our notice of privacy practices and financial policies. We appreciate your understanding and cooperation/

Consent for Treatment:
I consent to the provision of medical treatment, which may include, but it not limited to, routine examination, diagnosis/diagnostic tests and general treatment to be performed by Metrolina Dermatology. I acknowledge that no guarantee or assurances have been provided to me as to the outcome of any examination or treatment. I understand that if further medical procedure(s) or surgery is required, I may need to sign specialized consents.

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Paperwork: We request you routinely update your paperwork to ensure we have all the correct information on hand for billing purposes and to ensure excellent clinical care. This paperwork allows us to bill insurance in a timely manner and from preventing balances being unnecessarily transferred to you, the patient.

Consent to the use and disclosure of health information for treatment, payment or health care operations:
I authorize Metrolina Dermatology to use and disclose my protected health information in order to carry out treatment, payment or healthcare operations. I acknowledge that I have been presented with the Notice of Privacy Practices which provides a more complete description of how my protected health information may be used or disclosed. I understand I have the right to review the Notice prior to consigning this consent. I understand that Metrolina Dermatology reserves the right to change their notice and information practices and that I may obtain a copy of the revied notice by requesting a copy from the office. An electronic version of our Notice of Privacy Practices may be found by visiting our website.

Missed appointments/Cancellations: We request a 48 hour advanced notification of cancellations and reschedules. We try to notify all patients of upcoming appointments using our computerized calling system and/or by reminder phone calls directly from the office. **There is a $30 no-show fee for mid-level office visits, $50 fee for MD office visits, $150 fee for excision appointments, and $250 fee for mohs surgery appointments**. Three (3) no-shows/late cancellations (less than 48 hours) will result in dismissal from our practice

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Insurance: Our practice is contracted with most commercial insurances and Medicare. We do not accept Medicaid. As a contracted provider, we agree to accept adjusted fees from your insurance company and bill in accordance with CPT and ICD 10 guidelines. We collect co-pays at the time of visit. You will be notified of deductibles and other outstanding balances after your claim has been processed by your insurance company. The patient is responsible for providing the most up to date insurance information prior to, or at the time of service. Patient is responsible for payment of services rendered in the event the incorrect insurance information was provided at the time of service.

Cosmetic Procedures: For all cosmetic and laser procedures, **payment is expected in full at the time of procedure.** A non-refundable deposit of 50% of the service is required at the time of booking. This deposit will be applied to the total cost of your treatment. **We have a 48 hour cancellation no show fee of 50% of the service for all cosmetic appointments. If you cancel or no show before the 48 hour window, your deposit will go towards your next appointment. These no show fees are non-refundable.** You authorize Metrolina Dermatology to securely store your credit card/debit card on file. You also consent to Metrolina Dermatology charging your card up to $250 for a missed appointment or late cancellation that does not meet the 48 hour notice.

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Lab Fee: Metrolina Dermatology and Skin Surgery Specialists use an outside laboratory for pathology (biopsy or other) services. The lab will bill you directly for these services.

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Patient is Responsible for Total Charge: Payment is required for all services at the time they are rendered. We will collect applicable co-payments, co-insurance, and deductibles at the time of service. Patients will be charged in full for any unpaid copayments or deductibles. Patient balances will be set by the adjusted rates as determined by our contract with your insurance company. In accordance with our contracts and Medicare guidelines we cannot make adjustments to these fees or the codes charges. If your insurance requires a referral and the necessary referral was not obtained prior to services rendered, the patient (or party responsible for billing as listed below) is responsible for total payment of services rendered. Any remaining balance must be paid before being seen for future appointments.

Initial: _____

Autopay Policy:

As part of our financial policy, we use autopay. Please note, Medicare, Medicare Advantage (replacement plans), and Tricare are exempt from this policy. I authorize Metrolina Dermatology to maintain my credit card information securely on file. This card may be used to pay for any patient responsibility amounts not covered by my health insurance, including co-payments, co-insurance, deductibles, and non-covered services.

- I understand that after insurance processed your claim, you will receive a notification of the remaining balance and the amount to be charged to my credit card on file. My credit card will be charged 10 days after notification is sent.
- I understand that Individual payments will not exceed $300 per transaction and will be charged every 28 days until the balance is paid in full.
- If a charge to my card is declined for any reason, I agree to provide a new valid credit, debit, or HAS card within 10 business days.
- If a new payment is not provided within this timeframe, I understand that a $25 declines card fee may be assessed
- I understand that if I choose not to provide a credit card on file, a $100 deposit will be required at the time of service, in addition to any applicable co-pays. This deposit may be refunded after insurance has processed the claim, provided that no balance is due.

Initial: _____

My signature below indicates that I have read and agree to the above written Notice of privacy practice, financial policy, cancellation policy, and credit card on file policy of Metrolina Dermatology. I authorize release of any medical information necessary to process any claims filed

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Signature of Patient (or Legal Representative) Date