FINANCIAL POLICY

(Includes ABN, Privacy Notice & Rights, and Medical Consent)

Acceptance of services by Wolverine Dermatology is consent of the following policies published by Wolverine Dermatology, PC

PAYMENT AND BALANCES:

- Co-payment is due in full at the time of service. A down payment of $100 will be collected at the time of service for all high deductible plans. We will reserve those funds for your appointment. If payment is not received from either you or your insurance company within 90 days from the date of service your account is subject to collection review and referral to an outside collection agency.

- Wolverine Dermatology requires a credit/debit/HSA card be placed on file for any surgical procedure appointments. Any balance not paid by insurance will be charged to the card on file.

- Credit balances $5.00 and above will be credited back to the patient after 9months if no further appointments are schedule. Credit balances of $4.99 and below will be credited back to the patient if able to credit electronically through card payment system. If not, the balance will remain on the patient's account and available for cash reimbursement or use for next appointment charges.

INSURANCE:

- Please be prepared to present your driver's license and all insurance cards to the receptionist upon check-in each time you are seen for medical services.

- For those patients covered by an insurance plan we will file the claim on your behalf as a courtesy. Any charges that are not paid by your insurance company are your responsibility. We will mail a statement for any outstanding balances and payment is expected in full upon receipt. Your insurance policy is a contract between you and your insurance company.

- Patients without insurance, or insurance plans that we don't participate with, should be prepared to pay for medical services upon completion of your visit. We will provide you with a receipt for your records.

- It is the patient's responsibility to know the terms of their insurance plan. That includes any non-covered services and out-of-pocket costs. Agreement to accept services for insurance non-covered services is agreement to accept full financial responsibility for such services and therefore payment will be due within 30-days of service.

REFERRALS:

- Patients requiring a referral are responsible for making sure your visits with our office are authorized by your primary care physician. This authorization must be obtained before your scheduled visit. It is your responsibility to make sure Wolverine Dermatology, PC. has received the authorization. Please let us know in advance if your insurance company requires this.

NO SHOW POLICY:

- If you are unable to make your appointment, please call us at least 24 hours in advance to cancel or reschedule the appointment. A "No Show" fee of $50.00 will be charged for missed appointments or late cancellations. If any members of a family no-show/late cancel a total of three of more times combined in a 24-month period, the family may be discharged from the practice. Patient No Show balance must be paid in full prior to another appointment being made.

ASSIGNMENT OF BENEFITS, PATIENT FINANCIAL RESPONSIBILITY and ABN:

- Patient authorizes payment of medical benefits by the insured directly to Wolverine Dermatology, PC. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to me. Furthermore, I understand it is my responsibility to know/understand my plan benefits. I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary but are later determined unnecessary by the payer. I agree to pay all services within 90 days. I authorize Wolverine Dermatology, PC to release any information required to process my claim. The request shall remain in effect until revoked by myself in writing.

RETURNED CHECKS:

- A $25 service fee will be assessed to your account for any returned checks.

I have read and fully understand this financial policy. I also understand that Wolverine Dermatology, PC has the right to amend this policy at any time without prior notice to patients.

PRIVACY NOTICE AND PATIENT RIGHTS:

- Patient hereby affirms that a copy of the Notice of Privacy Practices has been made available. Under federal law 104-191, also known as HIPPA, the patient is entitled to receive a copy of these notices.

- Patient understands that signature on this acknowledgement signifies patient's knowledge that copies of both Patient's Rights and Responsibilities and Notice of Privacy Practices are available request and/or that they have received a copy.

MEDICAL CONSENT:

This consent provides Wolverine Dermatology with patient and/or known legal medical guardian permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

- I voluntarily request a physician and/or Wolverine Dermatology staff, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought the patient to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

- Patient hereby authorizes Wolverine Dermatology provider(s) to disclose to the referring provider, contracted insurances, and any other party providing proof of patient's approval with any and all medical information required to make medical decisions or financing relating to patient and patient's care. Patient agrees to waive all rights and privileges allowed by law relating to disclosure of confidential information and release the facility, its agents, and employees from legal responsibility arising from the release of the information.

By State law, you must be advised that: THE INFORMATION YOU AUTHORIZE FOR RELEASE MAY INCLUDE INFORMATION THAT COULD BE CONSIDERED INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASES, WHICH MAY INCLUDE, BUT ARE NOT LIMIGTED TO, DISEASES SUCH A HEPATITIS SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME ("AIDS").

I certify that I have read and fully understand the above statements, and consent fully and voluntarily to its contents.

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