Westford Dermatology & Cosmetic Center

Financial Policy

Thank you for allowing WDCC to be your healthcare provider. WDCC is committed to the success of your medical treatment and care. Our practice will work with you to help you fulfill your payment responsibility. We will file your primary and secondary medical claims for you. It is imperative that you provide us with current and accurate insurance information at the time of your appointment. We will scan a copy of your insurance cards at the time of your visit. If you fail to provide insurance information, you will be considered **Self Pay** and will be required to make payment arrangements at the time of service. It is important for you to understand that you have the contract with your insurance carrier and you will need to help us work with your insurance carrier to expedite the reimbursement process. **As The patient, you are responsible for any unpaid balance not contractually covered by your insurance.** You have final responsibility for payment for services provided. Your participation in the process is essential.

Privacy Policy: As required by law, WDCC maintains a privacy policy dedicated to the protection of our patient's medical information.

Medicare: WDCC is a participating Medicare provider. The patient is responsible for their Medicare co-insurance, deductibles and any services rendered that are not covered by Medicare.

Medicaid: The patient is responsible for any amount for services provided on dates that are not eligible for coverage. The patient is responsible for any services rendered that are not covered by Medicaid. Medicaid does not allow patients to be seen in the office without a referral. (If a referral is needed).

Managed Care Plans: In order to see a specialist, some insurance plans require a referral from the patient's Primary Care Physicians, (PCP) or pre-certification before treatment can be rendered. **It is the patient's responsibility to ensure we have this referral or pre-certification prior to the visit.** If we do not receive the necessary referral or pre-certification, the patient will be responsible for payment or will need to reschedule their appointment. **All co-pays are due at the time of service.**

Commercial Plans: WDCC has established fees that are usual and customary for this healthcare service area. Every insurance carrier has their own usual and customary fee schedule; however, the patient is responsible for payment regardless of the insurance carrier's arbitrary determination of rates. **All Co-Pays are due at the time of service.**

Non Covered Services: Some services we provide may be deemed not medically necessary by your insurance carrier or not a covered benefit by your specific policy, therefore, not paid by your insurance. Many cosmetic procedures we provide are not covered by insurance. The patient is responsible for payment at the time of service for all services not covered by insurance.

Laboratory Services: Some services, such as biopsies or surgery, require specimens be sent to a laboratory for processing. The patient may receive a separate bill from Miraca Labs, Lowell General Hospital Lab (LGH) or any other lab used. **The patient is responsible for payment for all laboratory services not covered by their insurance.**

Self-Pay Patients: Patients who DO NOT have insurance coverage are considered to be Self-Pay. Self-Pay Patients will be required to make payment arrangements prior to services being rendered.

Payment Arrangements: WDCC may consider payment arrangements for those patients who need assistance in meeting their account obligation. WDCC reserves the right to set the terms, conditions and to charge interest for any payment arrangements.

Credit Cards: WDCC accepts Visa, MC, Amex and Discover. Other forms of accepted payments are Cash, Check and Debit Cards.

Returned Check Policy: WDCC will charge a $25.00 dollar fee for each check returned by our bank for non-sufficient funds.

Co-Pays & Deductibles: We cannot waive co-pays or deductibles. You are responsible for any co-pays, co-insurance, deductibles or non-covered services as required by your insurance carrier.

Missed appointment fee: WDCC may charge a fee for missed office visit appointments, when the patient fails to give appropriate notification. A cancellation notice must be received twenty-four (24) hours in advance of the scheduled appointment. A twenty-five ($25.00) charge may be applied for failure to meet this requirement.

Late Fees: WDCC may charge a $7.00 (seven dollar) monthly billing fee for delinquent accounts that are (45) forty-five or more days past due.

Interest Fees: WDCC reserves the right to charge a monthly interest fee as defined by state law for delinquent accounts considered to be past due.

Collection Agencies: Should it become necessary for WDCC to send a patient account to a collection agency, the patient will be responsible for any and all fees associated with the collection effort of the account, to include reasonable attorney fees, court costs, collection charges and interest. If your account is over 90 Days past due, it will go to a collection agency.

PATIENT ACKNOWLEDGEMENT and AUTHORIZATIONS:

Authorization for treatment: With your signature below, WDCC is hereby authorized to conduct examination, perform procedures as are medically required and administer treatment and medications as deemed necessary or advisable.

Authorization for Release of Information: With your signature below, WDCC is hereby authorized to release a complete report of services rendered, diagnosis, findings and details of treatment and progress for the purpose of receiving payment for such services rendered. Recipients of such information may include authorized billing agents , insurance carriers, employer's workers compensation insurance company, other third party payers, the Social Security Administration under Title XV111 (18) of the Social Security Act, Professional review organizations or other intermediaries responsible for payment for services rendered. The release of information consent may be revoked at any time by giving written notice. If release of information is refused, the patient will be held responsible for payment of all charges for services rendered.

Authorization for Assignment of Benefits: In consideration of medical services provided, with your signature below, WDCC is given all rights title and interest to the medical reimbursement in accordance with the terms and benefits of the patient's insurance policy or other health benefit including Medicare Part B. The patient will be fully responsible for payment of any and all charges not covered by insurance.

I have read this Finical Policy and Authorizations. I understand that there is no guarantee or assurance as to the results that may be obtained from any treatment. I understand the terms and conditions outlined herein as confirmed by my signature below.

_____ _____

Patient Signature or Responsible Party Date Signed

Patient's printed Name _____ DOB _____

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