Patient Name _____

Rocky Mountain DERMATOLOGY

Authorization for Credit Card

NOTE: We do not keep any credit card information on file, in our office or on any computer we have in our office. We use a secure gateway that is completely compliant as required by law (similar to any major retailer, hotel, hospital or other healthcare provider).

AUTHORIZATION: Until further notice, I authorize Rocky Mountain Dermatology, PC to charge the patient responsible balances on my account to the following credit card:

Circle one: **Visa** **MasterCard** **Discover** **AMEX**

Please check if card is an HSA/FSA card: _____

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining to be paid by me. I agree that Rocky Mountain Dermatology, PC may charge my credit card the balance due when they receive a copy of the EOB. I also understand that Rocky Mountain Dermatology, PC may charge my credit card any open balance due as well, if they determine that a prior balance exists.

Signature:_____ **Date:**_____

Printed Name:_____

Email (if you would like an email receipt): _____

Financial Policy

Thank you for choosing Rocky Mountain Dermatology. We appreciate your trust in us and the opportunity to serve you. As part of our practice, we try to offer efficient and helpful billing services. To this end, we ask you to read the following statement about our financial policy. Please sign prior to any treatment.

- **Payment is required at time of service for: self-pay charges, copays and cosmetic procedures. We accept cash, check or credit card.**
- **All account balances must be brought current before services are rendered.**
- **A credit card must be on file prior to any treatment. If you choose not to provide a credit card, we will charge you for your visit in full on the date of service.**
- **Patients arriving 20 minutes or more late for a scheduled appointment will be rescheduled.**
- **If you need to cancel or reschedule an appointment, please notify our office 24 hours in advance of your scheduled appointment.**
- **A $25 fee will be assessed to your credit card if you fail to show for a schedule office visit without canceling 24 hours prior.**
- **A $100 fee will be assessed to the credit card you have on file if you fail to show for a procedure that requires 1 hour or more, without canceling 24 hours prior.**
- **Additional fees accrue when other servicers are rendered during a consultation. These fees include but are not limited to cryotherapy, biopsies and pathology fees.**
- **A $25 finance charge will be added to checks with insufficient funds.**
- **A $25 finance charge will be added at the beginning of every billing cycle if the account is not made current.**
- **The credit card on file will be charged if payment is not received within 30 days.**
- **Any bill not paid after 60 days of service will be sent to a collection agency and will be assessed further collection fees from the collection agency.**

Insurance Plans:
We are happy to bill insurance plans with whom we participate. Once we receive payment in the form of an explanation of benefits (EOB), we will make our contractual adjustment and send you a bill for any balance due. If payment is not received within 30 days of the EOB from your insurance company, we will charge your credit card on file. **Your insurance policy is a contract between you and your insurance company.**

Out of network insurance plans:
As a courtesy to you, we will bill your insurance carrier if you provide us with complete insurance information. **Your insurance policy is a contract between you and your insurance company**. We are not a party to your contract. If your insurance company has not paid your account within 30 days, the balance will become your responsibility and a bill will be mailed to you. At this point it is your responsibility to follow up with your insurance. We are happy to assist if your insurance company needs further documentation. In addition, our practice is committed to providing the best care for our patients. Our charges are within the usual and customary charges for our specialty in the Boulder area. You are responsible for payment regardless of any non-participating insurance company's arbitrary determination of usual and customary rates. If payment is not received within 30 days after the charges are turned to guarantor responsibility, we will charge your credit card on file.

Thank you for understanding our Financial Policy.

I, _____, have read, understand and agree to the Financial Policy.

Print Name

X_____ _____

Signature Date