DCI Dermatology Clinic of Idaho

CONDITIONS OF TREATMENT

Thank you for choosing us at Dermatology Clinic of Idaho ("Practice," "us," "we," "our") as your health care provider. Our main concern is that you receive the proper and optimal treatment needed to restore and maintain your health. This Conditions of Treatment document outlines several of our policies that impact you, as well as certifications and consents that you provide to us to enable us to use your information for various purposes that are part of our relationship with you. Therefore, if you have any questions or concerns about any of the policies, certifications, or consents contained below, please do not hesitate to ask our staff.

1. **FINANCIAL POLICY:**

- Your insurance will be filed as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles and other patient responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.** The final cost is not complete until the finished documentation of that visit is reviewed for accuracy. Any price quoted to you before your visit or at the exit desk after your visit are estimates. We strive to make sure that all charges are accounted for at check out, however the completed billing may differ from that estimate.
- In the event your insurance company does not pay the claim within a reasonable amount of time (45 days) then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.
- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit in full becomes your responsibility.
- It is the policy of this office that the adult presenting a child/minor for treatment is responsible for payment.
- A 24 hour notice is required for cancellations. A fee may be charged for missed office visits and the full price for laser or cosmetic procedures will be charged if a 24 hour notice is not provided
- Cosmetic procedures will not be billed to insurance and the cost of the procedure will be due at time of service. Your provider will determine if procedures are cosmetic or medically necessary.

The treatment of skin conditions depends on the type and location of the growth and the symptoms you are having. Your provider will discuss the appropriate treatment options with you. The most common forms of treatment include:

Curettage is the process of scraping skin with a sharp surgical instrument to remove skin tissue.

Shaving or Tangential Excision is the horizontal removal of a lesion.

Surgical Excision involves injection of a local anesthetic followed by cutting into the skin with a surgical instrument, removing the growth, and closing the wound.

Cryosurgery is the process of destroying skin tissue by freezing it with liquid nitrogen using an aerosol spray. This is common treatment form for warts and precancerous lesions.

Laser surgery uses an intense beam of light to burn and destroy tissue.

Multiple visits for cryosurgery or laser surgery are often required. This is especially true for treatment of warts. Each visit is billed separately. *The following amounts are not full charges but are the amounts* ***usually applied to your deductible*** *and what we will collect from you today if your deductible has not been met.*

Office Visits

New Patient	$110.00
Established Patient	$95.00

Biopsy

$95.00 – 120.00 initial

$55.00 - $65.00 each additional biopsy

Excision	$310.00 - $535.00
Lesion Destruction	$50.00 - $110.00
MOHS	$300.00 - $500.00

Pathology – *Required for all biopsies or lesion removals* $75.00 - $90.00

Your provider is required to send a biopsy or removal of a lesion to a lab for pathology services where tissue samples will be read by a pathologist. You will receive a bill for those services separately. We use a lab of our choice unless you request otherwise at the time of service.

2. **FINANCIAL AGREEMENT: The undersigned in consideration of the services to be rendered to the patient is obligated to pay the Practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical Practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the Practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.**

3. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.

4. **CONSENT TO EMAIL, CALLS AND TEXT COMMUNICATIONS:** If at any time you provide an email address or residential or wireless/mobile telephone number to the Practice, **you give your prior written consent to receive emails, calls and text messages for service-related communications to such email address(es) and phone number(s).** Emails, voicemails and text messages have inherent privacy risks, especially when access to your computer or mobile device is not password protected, is shared by others, or access is provided by your employer or public facility. Further, consenting to receive emails, calls, and/or text messages from the Practice, you understand and acknowledge that communications transmitted via unencrypted email or via text messages over an open network are unsecure, and could be accessed by an unauthorized third party in transit. Please do not send any information that is considered especially sensitive through these communication channels (e.g., medical diagnosis information, personal health history), as it may be received or accessed by unintended recipients, intercepted, altered or used without authorization or detection.

   You may notify the Practice if you wish to opt out of certain email messages, phone calls and text messages. Please understand that you may continue to receive services communications via email, however, in order for us to fulfill a request or communicate with you about your account. In addition, we may still respond to any communications you initiate and send to us, including via phone or text, in order to respond to your request or question even if you have previously told us that you do not wish to be contacted using those communication methods.

   - Message and data rates may apply.
   - Please also note that messages are unencrypted, and unencrypted messages, including email and text messages, may be intercepted or received by unintended third parties, and/or stored or archived by service providers and system operators.
   - You certify that you are the user and/or subscriber of any email address and telephone number you provide to

Practice and accept responsibility for email, call and text communications sent to or from this address or number. You agree to notify Practice in writing in the event your email address or telephone number changes.

***Service-Related Communications*:** Service-related communications that you consent to receive include but are not restricted to communications regarding billing and payment for products and services, appointment reminders, and other healthcare communications and communications about your condition(s), care, treatment, referrals or appointment(s).

By signing below, you certify that you are the user and/or subscriber of the email address and/or mobile number previously provided, and accept full responsibility for emails and/or text messages sent to or from this address or number. You agree to notify the Practice in writing in the event your email address or mobile number changes.

There may be a delay when responding to messages; thus, if you have an urgent situation, you should not rely on messages sent to the Practice to request assistance, but instead should seek assistance by means consistent with your needs (e.g., by contacting your provider/care team directly or calling 911).

To the extent permitted by law, you hereby agree to hold the Practice and its affiliates harmless from any and all claims and liabilities arising from or related to emails or text messages sent to the email address and/or number previously provided.

I have read and fully understand the above Conditions of Treatment and have been given the opportunity to ask questions.

_____ _____

Signature of patient (or legal guardian) Date

Email address: _____

Telephone: _____ ☐Mobile ☐Residential

If other than patient:

_____ _____

Relationship of Representative Reason individual is unable to sign (i.e. minor or legally incompetent etc)