REVELUS Dermatology

PATIENT FINANCIAL POLICY AGREEMENT
APRIL 2023

Board-Certified Dermatologists

Thank you for choosing Revelus Dermatolgoy for your care. We aim to deliver outstanding and transparent service. It is important that patients understand their rights and responsibilities. Herein, Westgate Skin & Cancer, PLLC dba Revelus Dermatology will be known as "the Practice."

PLEASE REVIEW AND INITIAL EACH POLICY

Scheduling Policy: The Practice requires a Credit Card on File (CCOF) or an on-account deposit to hold appointments. The Practice securely stores and encrypts (vaults) card information, and once stored, card information cannot be retrieved.

_____

Select One (Required)

☐ **CCOF**: I understand, consent, and authorize Revelus Dermatology to securely store my card on file and charge my card for any cancellation or rescheduling fees, telemed visits, or release of record requests.

☐ **Deposit**: I understand, consent, and authorize Revelus Dermatology to keep a $50 deposit for consults or a $200 deposit for advanced procedures

Select One (Optional)

Auto Bill: I do not want to receive a paper statement. You may automatically charge the card on file for any balance under:

☐ **$100** ☐ **$300** ☐ **$1,000** ☐ **All**

Financial Responsibility and Authorization to Treat: I acknowledge that, except as outlined by my health insurance, I am financially responsible for all charges associated with services, including non-covered services, rendered by the Practice. I understand that I may consult my insurance company before receiving care if I have any inquiries. I reserve the right to refuse treatment for any reason, including financial limitations. I authorize the Practice's providers and staff, at their discretion, to perform medical treatment and procedures on myself or the designated patient.

_____

In-Network Insurance Claims, Assignment, and Estimates: I understand and authorize the Practice to bill all provided in-network insurance policies for covered services rendered. I understand and consent to the release medical documentation to my insurance company associated with covered services. I authorize assignment of insurance payments to be made directly to the Practice for all insurance benefits. I understand that the Practice will verify my eligibility and benefits for covered care with my insurance company, but verification of benefits is not a guarantee of payment or coverage. I understand that I have the right to seek care outside of the Practice should I require that my covered care not be disclosed to my insurance carrier.

_____

I consent to pay at the time of service for:

- Co-Pay estimates
- Deductible estimates
- Co-Insurance estimates
- Any other estimated out-of-pocket costs

I understand that I will be billed if:

- My insurance company pays less than what is estimated
- My insurance company denies my claim
- My insurance company does not pay within 90 days
- My insurance company recoups payment or benefits at a later date

Self-Pay, Out-of-Network Insurance Claims, and Packages Policy: I acknowledge that payment is due in full at the time of service and I am responsible for obtaining a receipt. Out-of-network benefits are between myself and my insurance company, and I am responsible for filing and managing out-of-network insurance claims. I understand that elective services or packages must be purchased in full during my visit and previously rendered services are considered separate. Packages expire one year from the purchase date. All completed services are non-refundable.

_____

Practice Fees and Appointment Cancellation Policy: I understand and consent to pay the following fees not covered by my insurance. All appointments must be cancelled or rescheduled 24 business hours in advance.

_____

- **No-Show Fee** – $50 for all medical consults, cosmetic consults, basic medical procedures, and basic cosmetic procedures
- **No-Show Procedure Fee** – $200 for all advanced procedures that are 20 minutes or more such as fillers, surgeries, etc.
- **Returned Check Fee** – $50 in addition to any outstanding balance if my check is returned for any reason
- **Delinquent Account Fee** – I will pay my past due balance and an additional 34% service fee if my account is sent to collections
- **Re-Instatement Fee** – $200 if I am dismissed from the practice, and upon approval from the medical director, reinstate my care
- **Release-of-Records Service Fee** – $25 for the first 500 pages, $50 for over 500 pages for any request received with my signature
- **Prior-Authorization Appeal Letter Fee** – $50 fee per appeal letter at my provider's discretion. Payment not a guarantee of approval
- **Prior-Authorization Peer-to-Peer Review Fee** – $150 fee per review at my provider's discretion. Payment not a guarantee of approval

Pathology and Lab Fees: I authorize to be billed by an external lab for ordered services rendered. I understand that certain procedures, such as biopsies or cultures, necessitate pathology and/or lab services. I will make financial arrangements directly with these entities. Fees may vary from $100 to $400 per sample/specimen, and determination of fees may only be possible after orders are processed.

_____

Product Purchases: Product Purchases: I acknowledge that the Practice collaborates with Dermly for product purchases and fulfillment. All product purchases are final. In the event of an issue with the product, a one-time courtesy exchange for a similar or like product is allowed. Products used more than 25% are ineligible for exchange. Additional terms and conditions can be found at dermly.com/terms.

_____

SIGNATURE

I understand that my signature below confirms that I have read, understand, and consent to Revelus Dermatology's Financial Policies.

Patient, Guardian, or Responsible Individual Signature	Patient Name	Date Signed