

MICHAEL J. HUETHER, M.D., P.C.
ARIZONA SKIN CANCER SURGERY CENTER, P.C.

Thank you for choosing our practice for your care. As part of our commitment to service, we make every effort to offer efficient and helpful billing services. To this end, we require you to read, understand, sign and date the following, prior to any evaluation or treatment. In conjunction with this policy, we also ask that you read and understand our Patient Rights and Responsibilities.

It is essential that you bring your current primary and secondary insurance card to each visit, so that we have the most accurate and up-to-date information to submit charges to the insurance carrier on your behalf.

MEDICARE:

We participate with Medicare and we accept assignment. Patients are responsible for meeting their annual deductible and paying for the 20% co-insurance. We will file a claim with your secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, the patient may be billed.

PARTICIPATING PLANS-HMOs/PPOs:

*If Dr. Huether is a participating provider contracted with your insurance plan, copays must be paid at the time of service per health plan requirements. All other charges will be billed directly to the insurance plans in which we participate. Once we receive the correct payment, we will make our contractual adjustment and send you a bill for any unpaid patient responsibilities. These are due upon receipt of our bill. **It is your responsibility to know your coverage eligibility, deductibles, copays, referral and pre-certification requirements and whether or not Dr. Huether is a provider for your plan.** If the expertise of an outside lab is needed for a portion of your care (biopsy interpretations or second opinions), you may receive a separate bill from that lab for their services.*

NON-PARTICIPATING PLANS:

If Dr. Huether is not a participating provider contracted with your insurance plan, the expenses for your care will be your responsibility. When you arrive for your visit, you may be asked to sign a non-contracted waiver form, and you will have an opportunity to speak with our billing staff about the charges.

****ARIZONA SKIN CANCER SURGERY CENTER, P.C.:**

In some cases, depending upon the nature of your surgery, you may be treated in our licensed outpatient surgical center. You and/or your insurance plan may be billed separately for these services, including additional deductibles or copays. If you have any questions please contact your insurer or call our office and speak with our billing staff who may be able to help guide you.

PAYMENT:

We do not offer payment plans. If you do not have insurance, payment is due in full at time of service. For your convenience we accept cash, checks, or credit cards (Visa, Mastercard, Discover and American Express). After the initial consultation, if you have any questions regarding cost of procedures proposed, you may ask someone from the financial office to discuss anticipated costs with you. There will be a \$35.00 fee imposed for all returned checks.

*If you receive a patient balance statement in the mail, we can accept credit card payments made by phone. **A \$10.00 rebilling fee will be added each month if not paid in full within 30 days from the date of the statement.***

Thank you for taking the time to read and understand our Financial Policy. We welcome the opportunity to discuss any aspect of this policy if you have questions.

I have read, understand and agree to this Financial Policy and the Patient Rights and Responsibilities.

X _____ /_____/_____
Patient Signature/Responsible Party **Please Print Name** **Date**