Jimmy D. Schmidt, M.D.
819 Peakwood Dr.
Houston, TX 77090

****It is **<u>the patient's</u>** responsibility to be aware of your insurance benefits and acquire any referrals necessary prior to your visit.****

<u>FINANICAL POLICIES AND PROCEDURES</u>

At DermSurgery Associates/Jimmy D. Schmidt, M.D., we believe that all patients who come to this office deserve the best medical care that can be provided. In order for us to provide you with the highest quality medical care and current technology, we must ensure that we are able to meet the expenses necessary to operate this facility. To ensure that these expenses are met, we provide you with this agreement to acquaint you with our financial policy.

<u>PAYMENT AT TIME OF SERVICE</u>

As a courtesy, we will bill your primary insurance for all office visits and procedures except those deemed cosmetic by your insurance carrier. However, any portion not covered by your insurance due to deductibles, co-payments, cosmetic procedures, or remaining balances are due in full on the day of service.

<u>MANAGED CARE SUBMISSION OF CLAIMS</u>

It is important to remember that your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, **you are still responsible for what is not covered by your insurance.**

<u>BALANCES DUE AFTER INSURANCE PAYS</u>

If there is a remaining balance due after your insurance carrier pays, then we will mail out a statement to you. Payment arrangements can be made for special circumstances (but not guaranteed) by contacting the billing department ***<u>(713-791-9643).</u>*** **It is your responsibility to make contact with our billing department to make special arrangements**.

<u>PAYMENT OPTIONS</u>

Our office accepts Visa, MasterCard, American Express, and Discover. Our office also accepts check or cash.

<u>MEDICARE PATIENTS</u>

If you have Medicare as your primary insurance carrier, but you do not have a secondary insurance, you are responsible for the **20 percent at the time of service**. In addition, if the deductibles have not been met at the beginning of the calendar year, our office will collect toward it at the time of service.

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COSMETIC AND/OR MEDICALLY UNNECESSARY

You, the patient, will be responsible for any cosmetic or medically unnecessary procedures done at the time of service. A consent form will be provided and need to be signed to show your full understanding of non-coverage by your insurance company and your responsibility of payment in full. The payment will be due in full at the conclusion of the visit. A claim for the procedure should not and will not be submitted to your managed care plan.

MEDICAL RECORDS

A copy of your medical records is available to you at your discretion. A records release form needs to be filled out and signed. **There is a minimum of a $6.50 fee for the release of medical records**. This fee is due prior to the release of records. Once payment is received, then the records will be copied and mailed.

COSMETIC PRIOR AUTHORIZATIONS

In the event, that your insurance carrier is requiring a prior authorization for the medication considered cosmetic to be covered, we will be glad to assist you. There is, however, a $25 fee for all cosmetic prior authorizations that must be paid prior to this process being started. If you do not wish to pay that, we would be happy to assist you in trying to prescribe another medication that Jimmy D. Schmidt, M.D. P.A. may feel to be a comparable medication.

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Acknowledgement of Receipt: Financial Policy

I have read and received a copy of the DermSurgery Associates/Jimmy D. Schmidt, M.D., Financial Policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts may be assigned to a collection agency and I may be charged a customary, reasonable, and necessary collection fee in addition to what the outstanding balance is with DermSurgery Associates/Jimmy D. Schmidt, M.D. It is also important to note that I allow the collection agency to contact me at any telephone numbers listed including but not limited to cell phones as well as the address provided on the demographics sheet and/or patient update forms. If it becomes necessary to effect collections on any amount owed on this or subsequent visits, then the undersigned agrees to pay for all costs and expenses, including attorney fees. I hereby authorize the doctor to release information necessary to process claims and to secure payment directly from the insurance carrier.

_______________________________________ ________________________

Signature Date

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Print Name