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

FINANCIAL AND OFFICE POLICY

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. We also ask that you read and understand our Patient Rights and Responsibilities Policy, Notice of Privacy Practices and Advanced Directive Policy.

You authorize the release of medical information which could include HIV status, communicable disease, drug abuse information or pathologic slides/reports to and from my primary care and referring physician(s), outside laboratories or consultants, if needed, in the course of your examination and treatment as necessary to process insurance claims, insurance applications and prescriptions until revoked in writing.

You authorize payment of medical benefits to the physician and the Arizona Skin Cancer Surgery Center, P.C.

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. We also require that you provide a valid driver's license or photo ID to protect you from insurance fraud.

Cancelled Appointments:
Please call 48 hours in advance to cancel any appointments. There will be a $40.00 cancellation fee for appointments not cancelled at least 48 hours in advance.

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. If you do not have secondary insurance coverage, we will collect your 20% Medicare coinsurance at your appointment.

PARTICIPATING PLANS-HMOs/PPOs/Non-Participating Plans:
If Dr. Huether is a participating provider contracted with your insurance plan, copay's and deductibles 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. If Dr. Huether is not a participating provider contracted with your insurance plan, the expenses for your care will be your responsibility. Once we receive the correct payment from the insurer, we will make our contractual adjustment, and send you a bill for any unpaid patient responsibility. This is due upon receipt of our bill. ***It is your responsibility to know your coverage eligibility, pre-existing conditions, 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. You will be responsible for paying that separate bill.*
This office is not contracted with AHCCCS (Medicaid) or any AHCCCS plans. We are unable to accept you as a patient if you have AHCCCS as a primary plan. You are required to notify us if you are enrolled with AHCCCS.

*****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 will 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.*

PAYMENT:
All physician and facility co-pays and deductibles are due at the time of service. Please be aware that we will reschedule your appointment if you are not prepared to pay your physician and facility co-pay or deductible at the time of service. If you do not have insurance, payment is due in full at the time of service. We accept cash, checks, or credit cards (Visa, MasterCard and Discover). If paying by check, separate checks are required for the physician and the facility as they are two separate entities. After the initial consultation, if you have any questions regarding the cost of the proposed procedures, someone from our billing office will assist you. There will be a $35.00 fee imposed for all returned checks.

SELF PAY PATIENTS (no insurance)
You will be required to pay your estimated costs at check-in. You may incur a higher or lower cost than the estimated amount depending on the actual treatment that you receive. Any changes to your account will be adjusted at check-out. If you are not prepared to pay the estimated amount before your surgery, we will have to reschedule your appointment. If paying by check, please be sure to bring more than one check in case your estimate is adjusted at check-out.

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, the Patient Rights and Responsibilities Policy, the Notice of Privacy Practices and Advanced Directive Policy.

Patient/Responsible Party Signature _____ *Date* ___/___/____

Please Print Name _____ *Date of Birth* ____/___/____

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