

PATIENT ACCOUNT BILLING AND DISCLOSURE
POLICY NOTICE

NOTICE TO PATIENT:

Please be advised that Beauty thru Health Dermatology, PC maintains a Patient Billing and Disclosure Policy (the "Policy") which is outlined below. You should read this Policy and ask any questions you may have regarding its effect or operation. By your signature below, Beauty thru Health Dermatology, PC hereby acknowledges your receipt, understanding and consent to the following terms and conditions.

Once we have received payment in full from your primary insurance (and/or secondary insurance carrier if applicable), you will receive an invoice for that portion of the invoice balance which remained unpaid by any insurance or third party carrier ("Patient Owed Balance"). Such balances, for example, are usually for unpaid co-payments, non-medical deductible or non-covered services per your particular plan's benefits. *(Please note, Beauty thru Health is not a provider for(does not participate, bill or accept payment from) Medicaid, Sooner Care or Oklahoma Health "High Risk Pool" Insurance. Tri-Care insurance is accepted as secondary filing for Medicare only. Otherwise, we do not participate with Tri-Care insurance).*

We will bill you for all charges for a particular date of service that has been paid by your insurance or third-party carrier(s). You may still have claims that are being processed for other dates of service. However, we invoice you based on a specific date of service for which insurance payments have been received in full in order to clear the remaining balance for that date of service. Your **INSURANCE CO-PAY** and any **PATIENT OWED BALANCE** are **DUE IN FULL** at each visit. If these patient responsibilities can not be met, then we will have to reschedule your appointment. For information on your **CO-PAY**, call your insurance carrier. For information on your **PATIENT OWED BALANCE**, please call our billing service @ 1-866-688-5363.

Beauty thru Health Dermatology, PC will send out **only two (2) invoices** reflecting the **Patient Owed Balance** of your invoice. The invoices are sent out at thirty (30) day intervals. If payment in full on your **Patient Owed Balance** is not received during the sixty (60) day period, your outstanding account may be turned over to a collection agency **without any additional notice to you**. Invoices, which are turned over to a collection agency, are immediately deemed Delinquent Accounts. Any Delinquent Account is discharged from further care and services until the Delinquent Account is paid in full. **ADDITIONALLY, IF YOU DESIRE OUR SERVICES AND CARE IN THE FUTURE YOU MUST REINSTATE YOUR ACCOUNT BY PAYING ALL COLLECTION FEES AND COST INCURRED BY BEAUTY THRU HEALTH DERMATOLOGY, PC. THESE FEES NORMALLY INCLUDE A PERCENTAGE CHARGED BY THE COLLECTION AGENCY THAT RECOVERED PAYMENT OF YOUR OUTSTANDING AND UNPAID ACCOUNT. WE RESERVE THE RIGHT TO REFUSE FUTURE SERVICES UNTIL SUCH FEES AND COSTS ARE PAID IN FULL. ALSO, PLEASE NOTE THAT PAYMENT OF SUCH FEES ARE IN ADDITION TO ANY NEW SERVICES RENDERED BY BEAUTY THRU HEALTH DERMATOLOGY, PC.**

We also reserve the right to charge for a missed appointment when you fail to provide notice that you will not honor your appointment without good cause. Please call our office at least 48 hours prior to a scheduled appointment to avoid charges. Your failure to timely cancel an appointment will result in a charge of Thirty Dollars (\$30.00) for missed medical appointments and One Hundred Dollars (\$100) for missed surgical or treatment appointments added to your invoice for each such missed appointment. This assessment becomes your personal and individual responsibility and cannot be charged to your insurance or third-party carrier.

For your convenience, accounts can be paid using your MasterCard, Visa, and Discover Card. We also offer Care Credit Financing. For more information log on to the website at: www.Carecredit.com or call 1-866-893-7864 for more information on this payment program. We thank you for choosing Beauty thru Health Dermatology, PC for your dermatologic care and look forward to serving you.

Print Patient Name

Date of Birth

Signature of Patient or Guardian

Date Signed