Dermatology and Skin Cancer Center Of South Carolina, PC

Joseph M. Masessa, M.D., F.A.A.D.

PLEASE NOTE: IT IS THE PATIENT'S RESPONSIBILITY TO KNOW WHICH LAB THEIR INSURANCE COMPANY IS AFFILIATED WITH.

OFFICE POLICY & PATIENT RESPONSIBILITY

I. Your insurance coverage is a contract between you, the patient, and your insurance company (not the doctor).

A. Deductible is the patient's responsibility; even Medicare has a $131.00 deductible.

B. Co-insurance/co-payments are the patient's responsibility.

C. Co-payment is due at the time of the visit.

D. Referrals, if required, are the patient's responsibility. **YOU WILL NOT BE SEEN IF YOU DO NOT HAVE THE PROPER REFERRAL.** You may reschedule your appointment.

E. Filing insurance claims is a service provided without charge and in no way relieves you of responsibility of your bill.

F. We accept assignment with all insurance companies and Medicare. We do not accept Medicaid.

II **NOTE:** **ASSIGNMENT MEANS: WE ALLOW YOUR INSURANCE COMPANY TO DISCOUNT THE CHARGES. YOUR INSURANCE COMPANY WILL SET THE FEES FOR THE PROCEDURES PERFORMED. THESE FEES WILL REFLECT THEIR CUSTOMARY AND REASONABLE CHARGES AND ARE THE PATIENT'S RESPONSIBILITY.**

(Continued on Page 2)

EXAMPLE: If your insurance company pays 80% of covered/discounted charges, the patient is responsible for 20% of covered/discounted charges. The 20% is called the co-insurance.

If you have secondary insurance, we will submit the 20% for reimbursement.

Any charge your insurance company deems to be over reasonable and customary is not patient responsibility and will be adjusted accordingly.

III Your insurance company states these are the patient's responsibility and payments are due immediately.

A. Charges applied to your deductible
B. Charges applied to co-insurance
C. If you do not reply to your insurance company's requests for further information required to process the claim
D. If your coverage is not in effect at time of visit
E. If there are charges in coverage which you did not advise the doctor's office prior to the visit
F. If your coverage does not cover specific procedures as specified in your insurance handbook
G. If the insurance payments are sent directly to you, you are responsible for sending them to the office with the Explanation of Benefits (EOB)

IV Our goal is to provide the best medical care available while allowing your insurance company to establish customary and reasonable fees.

V Responsible Parent: In cases of divorced or separated parents, our policy is that the patient bringing the child into our office must be responsible for the full payment of all fees.

I HAVE READ AND COMPLETELY UNDERSTAND THE ABOVE OFFICE POLICY AND PATIENT RESPONSIBILITY.

______________________________ ______________________________

Patient/Guardian Date

5046 Highway 17 Bypass, Suite 103
Myrtle Beach, SC 29588
843-668-4104
843-668-4108 (fax)

14490 Ocean Highway
Pawleys Island, SC 29585
843-314-0629
843-314-0639 (fax)

Dermatology and Skin Cancer Center of S.C.

TO ALL PATIENTS:

If your insurance company requires a referral from your primary doctor, you must have it with you at the time of your visit. It is also the patient's responsibility to keep track of how many visits you have used on your referral and when it expires.

If you do not have a referral with you at the time of your appointment, we will not be able to see you and will reschedule your appointment.

This office cannot follow up with everyone's insurance company to check on individual referrals. THIS IS THE PATIENT'S RESPONSIBILITY.

Also, if you need a surgery or special procedure, we will check with your insurance company to see if a pre-certification is needed but it is the patient's responsibility to check with the insurance company regarding your benefits, co-pays, deductibles and what percentage you are responsible for paying.

Please sign the following:

I understand that any fees not covered by my insurance company, such as co-pays and deductibles, will be my responsibility to pay to Dermatology and Skin Cancer Center of S.C.

_________________________________ _________________________________

Patient's Signature Date

2046 Highway 17 Bypass
Myrtle Beach, SC 29588

14490 Ocean Highway
Pawleys Island, SC 29585

Dermatology and Skin Cancer Center Of South Carolina, P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dermatology and Skin Cancer Center of SC, P.C., to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent.

Dermatology and Skin Cancer Center of SC, P.C., reserves the right to revise its Notice of Privacy Practices at anytime. A revise Notice of Privacy Practices may be obtained by forwarding a written request to Dermatology and Skin Cancer Center of SC, P.C., Privacy Officer at: 35 Green Pond Road, Rockaway, New Jersey 07866.

With this consent, Dermatology and Skin Cancer Center of SC, P.C., may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Dermatology and Skin Cancer Center of SC, P.C., may mail to my home or other alternative location any Dermatology and Skin Cancer Center of SC, P.C., items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that Dermatology and Skin Cancer Center of SC, P.C., restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

BY SIGNING THIS FORM, I AM CONSENTING TO DERMATOLOGY AND SKIN CANCER CENTER OF SC, P.C.'S USE AND DISCLOSURE OF MY PHI TO CARRY OUT TPO.

I MAY REVOKE MY CONSENT IN WRITING EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ALREADY MADE DISCLOSURES IN RELIANCE UPON MY PRIOR CONSENT. IF I DO NOT SIGN THIS CONSENT, OR LATER REVOKE IT, DERMATOLOGY AND SKIN CANCER CENTER OF SC, P.C., MAY DECLINE TO PROVIDE TREATMENT TO ME.

(Detach above and give to patient for their records)

I ACKNOWLEDGE READING THE PRIVACY PRACTICE NOTICE ABOVE AND HAVE SIGNED BELOW TO ACCEPT.

______________________________	______________________________
Signature of Patient or Legal Guardian	Date
______________________________	______________________________
Patient's Name	Print Name of Patient or Legal Guardian