St. Petersburg Skin and Laser Center, LLC

FINANCIAL POLICIES AND PROCEDURES

At St. Petersburg Skin and Laser Center, LLC, we believe that all patients who are rendered care at this office deserve the best medical care that can be provided. 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 regarding our financial policy and your agreement to pay for services provided. Please sign and date this Agreement on the last page to indicate you accept these terms.

PAYMENT AT TIME OF SERVICE, FEES AND COLLECTIONS

Your insurance policy is a contract between you and your insurance company. We do our best to keep our contracts with insurance companies up to date and check that we are an in-network provider with your insurance company prior to any appointment. We also attempt to obtain prior approval from your insurance company for any procedures not done the same day as the office visit (ex. excisions, Mohs Surgery). However, every insurance plan is different and ultimately you are responsible for ensuring that we are an in-network provider with your insurance company. You are also responsible for obtaining estimate costs before procedures. Any bill from St. Petersburg Skin and Laser that is sent to your insurance company and not paid by them because we are out-of-network provider or you did not get approval for a procedure will be billed to you and you are responsible for payment per our policy below. We will not become involved in disputes between you and your insurance carrier. We do provide your insurance carrier with information regarding your diagnosis and treatment. We do not get involved in such matters as disputes regarding deductibles, copayments, non-covered charges and "usual and customary" charges. If your insurance carrier does not provide payment within 40-60 days after treatment, you will be responsible for payment. You are responsible for timely payment on your account. We require that you pay any amount not covered by your insurance, such as deductibles and copayments, on the day of service. If your plan requires you to pay co-insurance, you will be required to pay that on the day of service. St. Petersburg Skin and Laser, is required in accordance with its contract with your insurer to collect from you deductibles and copayments. We will determine your copay and how much of your yearly deductible under your policy has been met for the year. If you are unable to pay your copayment at check-in, another appointment will be made for you. Any additional payment owed will be collected in full at the time of service. If needed, we will work with you to arrange a payment plan.

We will request to see your current insurance card and photo identification at every visit so that we may bill the insurance company in a timely fashion. It is your responsibility to ensure

we receive current and valid insurance coverage information at each visit. It will be reviewed or copied every time you are here for a visit, no matter how frequently you are seen. If a claim is rejected because your insurance does not cover the type of service rendered, you will be held responsible for the outstanding balance. **Please call the telephone number on your insurance card before your appointment and they will assist you in finding out whether the service to be provided at the appointment is covered, whether a referral or prior authorization is required, and what your copay is and what your deductible is.** It is your responsibility to understand your insurance coverage. If your insurance does not cover the cost of your visit or procedure, you will be responsible for the charges for all services rendered.

Please educate yourself as to your coverage so that office visits, procedures, testing, and specialist referrals may be arranged to best suit your needs.

Once we determine your personal financial obligation or after your insurance company reimburses St. Petersburg Skin and Laser for a portion of your care, we may electronically email you one (1) statement. Payment is expected upon receipt of the statement. Any account past due by 30 days or more may be subject to submission to our collection agency. If your account becomes delinquent and is placed into our collection process, collection fees will be added to your balance and will be your responsibility. By signing our financial policy, you agree to pay these added fees, along with all costs associated with the collection of your account, including interest charges.

If a new problem is encountered, or if changes in treatment of a pre-existing condition are discussed in the process of performing a visit or exam, an additional copay and deductible payment may be incurred.

If you are seen in our office by a nurse or a medical assistant for minor medical services you may be charged a limited office visit, and applicable co-pays will be collected.

If you carry a balance on your account during the time you present at our office, a payment on your account will be required at the time of check-in unless a Credit Card is kept on file or a payment plan is in place. St. Petersburg Skin and Laser reserves the right to terminate any patient for nonpayment. Under unusual circumstances, we are willing to work out personalized payment schedules if you so require and can demonstrate need. We accept cash, check or credit card.

COPAYS AND DEDUCTIBLES

Copays and deductibles may be required by your insurance and plan. This is a contract between you and your insurance. We also have contracts with your insurance, and we are required to collect these at each visit. We will not waive any copay or deductible, so please do not ask us to. Failure to pay these at the time of service will result in your appointment being rescheduled.

CREDIT/DEBIT CARD ON FILE

We require a credit or debit card on file with our office, You authorize us to charge the debit or credit card for (1) amounts due, but not otherwise paid, at the time of your visit (including copays and deductibles), (2) no-show or late cancellation charges, (3) insurance discrepancies not resolved within 90 days following date of service, and (4) outstanding balances greater than 30 days past due.

You will receive a letter in the mail from your Insurance carrier that explains how much of your office visit they paid and how much you are responsible for. This is called an Explanation of Benefits, or EOB. This letter tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance to pay. We receive the same letter that you do. It arrives about 20 – 30 days after your appointment. We look at each Explanation of Benefits carefully and determine what your insurance has determined as patient responsibility. This is the same way we normally determine how much to send you a bill for in the mail. Once we receive this and determine how much is owed, we will electronically email you one (1) statement to the email we have on file associated with your account. Payment is expected upon receipt of the statement. If payment is not made electronically within five (5) business days, we will charge the credit card on file for the full amount owed.

We do not store your sensitive credit card information in our office. We store it in a secure fashion with a reputable financial firm called a gateway. We access your information only on this site to process a payment.

We will always work with you to understand if there has been a mistake, and we will refund you if we have made a billing error. We will only charge the amount that we are instructed to by your insurance carrier in the EOB and the amount that you have agreed to.

ELECTIVE PROCEDURES/COMETIC PROCEDURES/NON-COVERED PROCEDURES

Patients are required to pay the estimated self-pay portion of elective/non-covered procedures prior to services being rendered, base on insurance verification and eligibility of benefits.

SUBMISSION OF CLAIMS

We will submit your insurance claims. However, 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 payment of services regardless of the amount your insurance pays.

PAYMENT OPTIONS

Our office accepts most credit and debit cards. Our office also accepts valid check (with a valid driver's license). There will be a $50 fee for all returned checks. Once we have a returned check for you, we may require that all future payments be with cash, money order, cashier's check or credit card. Anytime a co-pay, deductible or balance is due, we will charge the fee to your credit card which will help to keep you at a zero balance and paid up in full with your credit card on file.

CASH PAYMENT

We will not accept cash at our office. Exceptions to this policy may be made at the discretion of the practice owner.

MEDICARE PATIENTS

If you have Medicare as your primary insurance carrier, but you do not have a secondary insurance, you are responsible for the deductible, copay, and co-insurance at the time of service. You are also responsible to pay for services not covered by your Medicare insurance unless you have a secondary insurance. You will be required to sign an Advanced Beneficiary Notice for non-covered services.

NON-CONTRACTED INSURANCE (Out of Network)

If you have an insurance plan that we do not participate with, you may or may not have out-of-network benefits. These benefits typically have a higher copay, coinsurance, and/or deductible out of pocket cost. You will be considered a self-pay, uninsured patient if you do NOT have out of network benefits and if your insurance does not pay for the service, you are financially responsible. Please understand that what your non-contracted insurance deems "allowable" may not cover the entire charge and you are responsible for any difference.

UNINSURED/SELF-PAY

Payment is expected at each visit. All other ancillary treatment and future care will be reviewed with you in order to make arrangements for payment. We require a $100 non-refundable deposit to be placed with us to schedule your first visit with us which will then be used toward the total cost of your first visit. If you fail to show up for your visit, this deposit will not be refunded.

MISSED APPOINTMENTS/NO SHOWS/LATE FOR APPOINTMENT

We understand that you may not be able to keep all your scheduled appointments or might occasionally be late. Please understand that missed appointments have a detrimental impact on our practice and other patients. They also affect our ability to serve other patients in need

of medical care. We understand there may be inclement weather or other circumstances that may require you to cancel your appointment. If you must cancel or re-schedule your appointment, please do so at least 1 business day in advance. Failure to cancel or reschedule an appointment at least 1 business day in advance will be considered a no-show. We reserve the right to charge you $50.00 for any no-show if permitted by law and your insurance contract. This fee is not covered by your insurance company. Payment of the missed appointment will be required prior to scheduling another appointment. St. Petersburg Skin and Laser reserves the right to terminate any patient with more than two no-show appointments upon 30 days written notice to the patient to seek medical help from another practice. Cosmetic appointments will have a larger amount for no-show fees.

If you are running late on the day of your appointment due to unforeseen circumstances, please contact our office immediately so that we can determine whether we can see you that day or if we will need to reschedule your appointment. If you are more than 15 minutes late for an appointment, St. Petersburg Skin and Laser may reschedule your appointment and refuse to see you at the originally scheduled time.

REFERRALS

If your insurance carrier requires a referral or authorization for your visit, it is your responsibility to make sure that our office receives current valid authorization. If you do not have a valid referral or authorization at the time of service, we will be unable to treat you until a valid authorization/referral is obtained, and you may be sent back to your primary care physician to obtain authorization prior to being treated or full payment will be expected at the time of service. Please remember that it is your responsibility to make sure we are on your plan's provider listing. We appreciate your understanding of the ever-changing requirements of managed care plans and our position to adhere to their policies or requirements.

FORMS AND MEDICAL RECORDS FEES

Due to the increasing costs of providing our patients with the highest standards of care, we must impose a charge for certain records and forms. It takes time for our providers and staff to retrieve and copy files, complete forms and write letters. The following charges apply:

FMLA, Disability, School forms not completed during an appointment, and Supplemental insurance forms $75

Patients will be charged for copies of medical records the allowed fee by the State of Florida: $1.00 per page for the first 25 pages, then $0.25 per page. There is no additional fee for for faxing records.

Dictated letters, extensive forms with review of medical records: $25 per page

Prior Authorizations: $25

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize St. Petersburg Skin and Laser: (1) to release any information necessary to insurance carriers regarding my illness and treatments; (2) to process insurance claims generated in the course of examination or treatment; and (3) to allow a photocopy of my signature to be used to process insurance claims for all services provided to me by St. Petersburg Skin and Laser. This authorization will remain in effect until revoked by me in writing.

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above- named health care provider any and all plan documents, summary plan description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose in action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under all applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it were the original.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES AND PROCEDURES OF ST. PETERSBURG SKIN CARE AND LASER CENTER, LLC.

_____

Signature

_____

Printed Name of Patient/Parent/Guardian

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Relationship of Signer, if other than Patient