I.A. Tangoren, M.D., PLLC
Dermatology & Dermatologic Surgery

NOTIFICATION OF FINANCIAL AND PRACTICE POLICIES

Please take the time to review and acknowledge receipt of our practice's financial and payment related policies. In this policy statement I.A. Tangoren, M.D., P.L.L.C. may be referred to as "the Practice" and includes all providers and employees of the Practice and the patient and/or responsible party may be referred to in the first person, as "I"/"you."

PATIENT RESPONSIBILITY:

We will answer questions relating to your insurance to the best of our ability, however, your insurance is a contract between you and your insurance carrier. It is your responsibility to know the terms of your coverage.

We will do our best to verify your eligibility at the time of service, however you or your responsible party accept responsibility for any and all charges deemed not eligible for coverage by your insurance carrier. You may also request that we do not bill your insurance coverage for certain services; however payment in full for those services must be at the time services are provided.

COLLECTION OF CO-PAYMENTS, CO-INSURANCE & DEDUCTIBLES & CHECK-IN/REGISTRATION PROCEDURES:

Co-payments, co-insurance amounts and outstanding deductibles are collected at check-in. It is your responsibility to bring your insurance card to all appointments and to pay applicable member cost sharing amounts at the time of check in. Your appointment may be rescheduled if your insurance card and member cost-sharing amounts are not provided at the time of service. We perform real-time insurance verification and obtain from your insurance carrier the most up to date information on co-payment and co-insurance amounts and outstanding deductibles. Your charges will be estimated based on your provider's estimate of the procedures and services to be rendered. If there is a balance due after actual services rendered, you will be billed by the practice for the outstanding amounts. Additionally, if the practice receives an EOB (Explanation of Benefits) from your carrier that shows you have made an overpayment a refund will be issued immediately).

REFERRALS and PRE-AUTHORIZATIONS:

You as the patient/responsible party must obtain any authorization or referral required by your insurance carrier for services provided by our Practice. You understand that failure to do so could result in additional out-of-pocket expenses. Referrals MUST be present at the time of your appointment or your appointment will be rescheduled.

IN-OFFICE PROCEDURE NOTIFICATION AT TIME OF SERVICE:

Some of the services provided in our office are considered surgical and may result in additional responsibility through co-insurance over your co-payment responsibility. You agree that you are responsible to obtain the authorization from your insurance carrier or other party before service is provided. You understand that your failure to do so could affect the benefits paid for the services provided and increase your personal cost.

MEDICARE:

If you are a Medicare beneficiary, you certify that the information given by you for payment under Medicare is correct. You request that payment of authorized Medicare benefits be made payable to I. A. Tangoren, M.D., P.L.L.C. for any services furnished to you by the Practice. You give permission to the Practice to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for services or to obtain payment of any claims relating to these services.

INSURANCES WE ARE CONTRACTED WITH:

If we participate with your insurance carrier, we will bill your insurance carrier for you. You, the patient or responsible party, are responsible for payment of your co-payment, co-insurance and/or deductible at the time of service. You are, by signing below, assigning your insurance carrier to make direct payment to our Practice.

INSURANCES WE DO NOT PARTICIPATE WITH:

If we do not have a signed contract with your insurance carrier and we are a non- participating provider, your status will be "self-pay" and you will be required to pay for your care at the time of service. We will courtesy bill your insurance company and refund you any payments made by your insurance carrier on your behalf. If you do not want us to courtesy bill, you may have a copy of the charges and codes associated with your care and you may submit these to your insurance carrier for reimbursement directly to you from your insurer.

SELF-PAY:

You understand that by not providing proof of insurance (a valid insurance card) or by requesting that your insurance carrier is not billed, charges for services are your responsibility. You may be required to sign a separate self-pay agreement. Payment in full is due at the time of service. Self-pay amounts due may be settled by credit or debit card or cash. We do not accept checks for self-pay services.

WORKER'S COMPENSATON:

The Practice does not participate with Worker's Compensation and cannot see new or established patients for work related problems. We are unable to provide care or treatment for any claim that may be related to work place injury or exposure. We are unable to submit claims to the Worker's Compensation Board and we are prohibited from seeing you as self-pay patient for conditions that may result in a worker's compensation claim (conditions that are job related or job exacerbated).

NO-SHOWS AND CANCELLATION POLICY:

If you are unable to keep an appointment or need to reschedule, please call our office at least 2 business days prior to the appointment. A charge of $50 for office visits & $75.00 for cosmetic and surgical procedures requiring a 30 (S30) or 60 (S60) minute slot will be assessed for all no-show or cancelled visits with less than 24-hour notification. This fee is patient responsibility and is not covered by your insurance.

Multiple no-shows or cancellations will be viewed as non-compliance and may result in discharge from our Practice. Patients who miss their initial new patient appointment will not be rescheduled without approval of the office manager.

GUARANTEE OF PAYMENT, PERSONAL BALANCES AND RELATED FEES:

You agree to pay all applicable charges, which are not paid in full by your insurance. You understand that charges deemed as patient responsibility by your insurance carrier or not covered by your insurance carrier are your responsibility and are payable upon receipt of an invoice from the Practice. All outstanding personal balances for which the patient or responsible party have received an invoice must be paid in full prior to being seen for scheduled appointments.

In some circumstances, the Practice may bill you directly for services unpaid by your Insurance Carrier after one hundred eighty (180) days.

The Practice will charge a $35.00 fee for all returned checks, credit card charge backs or ACH rejections (debit cards declined or charged back for non-sufficient funds).

In the event that you default on payment of your account, you understand that you are responsible for any and all costs incurred for the collection of your account, including interest, collection fees, court costs and reasonable attorney's fees.

You also understand and acknowledge that you are responsible to pay the Practice in full for services that my health insurer will not cover due to non-payment of my health insurance premiums.

You authorize The Practice, and/or any debt collection agency and/or debt collection attorney hired by The Practice, to contact you regarding your I. A. Tangoren MD PLLC account and any other accounts we service, or to recover any unpaid portion of your obligation to The Practice, through an automated or predictive dialing system or prerecorded messaging system, at the phone number (including any cellular phone number), or other contact information you have provided or subsequently provide to The Practice. You understand that you do not need to provide a cellular phone number to receive products/services here.

DUTY TO INFORM:

You acknowledge that it is your responsibility to notify the Practice of changes to your contact information (address, phone number), primary & specialty physicians and health care providers involved in your care, and responsible party for payment. Failure to do so could adversely affect the care you receive and the necessary communication of treatment information to your primary physician and may also result in your discharge as a patient.

ASSIGNMENT OF BENEFITS:

You hereby request that payment of authorized Medicare, and all other insurance benefits be made on your behalf to I.A. Tangoren, M.D., P.L.L.C. for any services provided to you and/or your dependents by any practitioner or employee of the Practice. You give the Practice permission to submit the necessary claims to Medicare or any private insurance carrier on your behalf.

AUTHORIZATION TO RELEASE INFORMATION:

You authorize release of your medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in your care. You further authorize any other individual or entity that has provided health care to you to release to I.A. Tangoren, M.D., P.L.L.C. any and all of your medical record information, whether in printed or electronic form, needed to provide you with necessary care. You may revoke your consent for the release of this information at any time, except to the extent that action has been taken in reliance on this consent.

PROMISE/WITHDRAWAL OF REQUEST FOR TREATMENT:

No promises have been made to you about the result of treatments or examinations that you will have while you are a patient of the Practice. You understand that if you decide to leave the Practice without being formally discharged, that this means you are withdrawing your request for treatment.

We reserve the right to change our policies. A copy of our current Notification of Financial and Practice Policies is posted at all times on our web site, www.drtangoren.com and available in the waiting room or from a receptionist.

WRITTEN ACKNOWLEDGEMENT OF PRACTICE POLICIES:

You acknowledge that you have received and had an opportunity to ask questions concerning the Practice Policies of I.A. Tangoren, M.D., P.L.L.C. You agree to the terms and conditions contained herein.

Patient's Signature _____ Date _____

Responsible Party _____ Relationship to patient _____