PRINT NAME:_____ **SOCIAL SECURITY NUMBER:**_____

FINANCIAL POLICY/HIPAA POLICY/HCFA RELEASE
MICHAEL E MURPHY, M.D. THE INDIANA SKIN CANCER CENTER, PC; THE INDIANA SKIN CANCER ASC, LLC

Thank you for choosing us. We appreciate your trust in us and the opportunity to serve you. As part of our practice, we try to offer efficient and helpful billing services. Please read the following statement of our financial policy and sign it prior to any treatment.

- Payment for non-covered or cosmetic procedure is due at the time of service.
- We accept cash, check, or credit cards.
- An 18% service charge will be added to bills over 30 days old.
- We offer an extended payment plan for patients meeting low income or financial hardship criteria.
- Amount collected, on your surgery date, reflects your insurance plan's 1. Deductible 2. Facility co-insurance 3. Specialist co-pay. ANY ADDITIONAL amount applied, by your insurance plan, will be the responsibility of the patient and billed at a later date.
- Self-pay patients will be required to make payment in full prior to the surgery date.

PARTICIPATING PLANS: Co-pay, co-insurance, and deductibles are to be paid on the date of service. We will be happy to bill insurance plans we participate in. Once we receive correct payment, we will make our contractual adjustment and send you a bill for any additional balance due.

MEDICARE: We participate with Medicare and accept assignment. Patients are responsible for meeting their annual deductible and paying for the 20% co-insurance on the date of the appointment. We will file a claim with your secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, the patient may be billed.

NON-PARTICIPATING PLANS & SELF-PAY PATIENTS: As a courtesy to you we will bill your insurance carrier if you provide us with complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account within 30 days, the balance will be assessed for payment. You should remit payment within 30 days or contact your insurance company to check on status of the claim. Please notify us immediately upon contacting your insurance company or if there is anything we can do to help settle this claim.

THE INDIANA SKIN CANCER AMBULATORY SURGICAL CENTER, LLC: In some cases, depending on the nature of your surgery, you may be treated in our licensed outpatient surgical center. You and/or your insurance plan may be billed separately for these services. If you have any questions please contact your insurer or call our office and speak with our billing staff who may be able to help guide you. Dr. Murphy is the Medical Director and owner of the Indiana Skin Cancer ASC.

OUTSIDE LABS: If the expertise of an outside lab is needed for a portion of your care (biopsy interpretation or second opinions), you may receive a separate bill from that lab for their services.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best care for our patients. Our charges are within the usual and customary charges for our specialty in our area. You are responsible for payment regardless of any non-participating insurance company's arbitrary determination of usual and customary rates.

CELL PHONE CONTACT: By providing a wireless telephone number, you and/or your guarantor consents to receiving calls by means of autodialed or prerecorded messages or artificial messages from our office or third parties in response to payment/bill collections or other matters.

ACKNOWLEDGEMENT OF HEALTH INFORMATION NOTICE: I am aware of the Notice of Health Information Practices (HIPAA) and understand this policy is available upon request.

_____ **(INITIAL)**

REQUEST PAYMENT FROM YOUR INSURANCE CARRIER: "I request payment of authorized Medicare, Medigap **AND/OR** the insurance carrier be made either to me or on my behalf to The Indiana Skin Cancer Center, PC, for any services furnished to me. I authorize any holder of medical information about me to release to HCFA and its agents and/or other insurance carrier any information needed to determine benefits payable for services.

_____ **(INITIAL)**

RELEASE OF PERSONAL HISTORY INFORMATION: I authorize The Indiana Skin Cancer Center, PC to release my PHI (including laboratory results) to the following family/friends: (Please list names below)

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Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I understand it is my responsibility to notify The Indiana Skin Cancer Center, PC of any changes to this release of information consent. I have read, understand and agree to this Financial Policy.

X_____ DATE _____

EMAIL: