Rochester Skin Cancer Center / Rochester Surgery Center P.C.
405 Barclay Circle Rochester Hills, MI 48307
248-293-0800

STATEMENT OF FINANCIAL POLICY

Thank you for choosing us as your health care provider! We are committed to the success of your treatment and care. Please understand that payment of your bill is part of this treatment and care. The following is our statement of financial policy, which we require all of our patients to read, understand, and sign prior to any non-emergent treatment or care.

In order for us to successfully bill your insurance company, we need complete information and require a copy of your insurance card at each visit. Please cooperate with our reception staff in providing this information.

About your insurance coverage:

- **Medicare**- As required we will file claims with Medicare. You are responsible to pay for services not covered under the Medicare program (such as cosmetic services) and all Medicare co-payments. If Medicare does not forward claim information to your secondary insurance carrier, our office will do so and attach the primary explanation of benefits**. **If you have a Medicare HMO or Medicare Advantage plan, please contact our office to see if we participate. We do not participate with all Medicare Replacement plans.**

- **Commercial/Indemnity Insurance**- Your policy is a contract between you and your insurance company. Since we are not a party to that contract, your account balance, and whether your insurance pays or not is your responsibility. As a courtesy, we will file a claim on your behalf. However, if your insurance does not pay within 60 days you will be responsible to pay the balance of unpaid charges and follow up with your insurance directly.

- **Managed Care Plan (PPO, POS, HMO)**- You are responsible for paying any co-payments, deductibles, co-insurance and non-covered services. **It is your responsibility to verify a physician's participation in your health plan prior to making an appointment.** Please understand that if you fail to do so your insurance carrier may not authorize the visit. We must comply with your insurance company's rules and generally insurance companies will **NOT** issue a retroactive referral for services.

- **Authorizations/Referrals**- If prior authorizations or referral is required, please contact your insurance company or your primary care physician at least one week prior to your appointment.
  Let them know you are having Mohs Surgery. Procedure Code: 17311 or 17313.
  In addition to the above your surgical site may require reconstruction. The reconstruction procedure codes may range from 13100 to 15740 depending on size, site and complexity.

- **You could receive two or more bills for services provided.**
  If reconstruction is needed this will be performed in the Rochester Surgery Center as an outpatient procedure. **If the surgical center is utilized you and/or your insurance company will receive separate statements for the physician services billed through the Rochester Skin Cancer Center, and for the ambulatory surgical center fee billed through the Rochester Surgery Center.** This is not a duplicate charge, but a separation of the facility and physician's fees.

- **Self-Pay or Self-Filing**- Patients who do not have insurance coverage, who are unable to provide us with valid insurance information, or who wish to file their own insurance claims are responsible to pay 100% of the charges at the time services are rendered.

- **Co-pay**- Co-pays are due at the time services are rendered.

Returned Checks: The fee for each check returned for insufficient funds is $25.00. This fee will be automatically charged to your account when your check is returned from the bank.

Cancellation/Rescheduling Policy: 48 hours notice is required for all cancellations/rescheduling of a surgery appointment. Any cancellations/rescheduling with less than 48 hours notice are subject to a $200 cancellation fee.

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STATEMENT OF FINANCIAL POLICY - continued

The surgical procedure may include a specific postoperative care for a period that can range from zero to ninety days which is determined by the specific procedure performed. During this global period following the surgery, this office will schedule periodic visits for dressing changes to monitor wound care and healing and suture removal. Please note the following:

1. If any additional surgical services are required during the postoperative period (such as incision and drainage of hematoma, repair of wound dehiscence, procedures to stop postoperative hemorrhage) a separate charge for such complications will be assessed.
2. Any visits required to inspect the status of wound care healing or any wound infections beyond the global period are billed as regular office visits plus any additional service that may be necessary. Note that any follow-up care beyond the designated postoperative period is not included in the cost of the surgery and will be billed based on the service(s) performed.
3. Appropriate co-payments will apply to services beyond the postoperative period.

The following list indicates the insurance companies that Rochester Skin Cancer participates with:

Medicare Blue Cross Blue Shield Humana PPO McLarenPPO United Health Care PPO Aetna PPO Beaumont Health Plan Cofinity/PPOM Priority Health Tricare

WE DO NOT ACCEPT HMO PLANS, i.e. BLUE CARE NETWORK OR HAP

WE DO NOT ACCEPT_MEDICAID PLANS

About our staff:
Our staff has been trained to understand many insurance policies, but they **DO NOT** have all the answers about your specific benefits. Please contact your employer for a copy of your *Benefits Guidebook*, or call your customer service number located on the back of your insurance I.D. card to obtain detailed information about your plan coverage.

I hereby authorize Rochester Skin Cancer / Rochester Surgery Center to release medical/billing information for purposes of claiming insurance benefits. I understand that I am responsible for any procedures not covered by my insurance. If Rochester Skin Cancer / Rochester Surgery Center does not participate with my health insurance, I accept responsibility to pay any fees that my insurance does not cover.

Thank you for reading and understanding our statement of financial policy. Please let our office staff know if you have any questions or concerns.

I HAVE READ THE STATEMENT OF FINANCIAL POLICY
I UNDERSTAND AND AGREE TO THE POLICY

_____ _____ _____
Patient's name (Please Print) Signature of Patient or Guarantor Date