

HILTON

dermatology + aesthetics

Billing and Payment Policy

Thank you for choosing Hilton Dermatology & Aesthetics to serve your dermatology needs. We are committed to treating you and your skin care needs with excellence and respect.

However, we have a responsibility to help our patients understand that balances they may be responsible for. Our practice participates with Medicare and most Managed Care plans in the area and our office will file these claims for you with your insurance carrier.

If you are a Medicare patient and do not have a supplement plan or Medicare Advantage Plan, you are responsible for payment of the annual deductible, coinsurance, and non-covered services at the time of service.

If you have a High Deductible Health Plan and have not met your annual deductible amount on the date of service, you will be asked to pay 100% of the allowed charges at the time of service. You will be billed for any additional amounts after the insurance processes the claim.

It is the policy of our office to ask you to provide the necessary information needed to verify your insurance coverage and file your insurance claim. **Please note that if you are unable to provide your insurance information, we will require that you pay in full for the services you received at the time of the visit. It is urgent that you bring your most recent cards to your appointments.**

All patients are expected to pay any deductibles, coinsurance or copay amounts owed at the time of service. Our office accepts cash, personal checks, debit cards and all major credit cards. There is a \$35 charge for all returned checks. Please be aware that:

1. Your insurance policy is a contract between you and your insurance company. **You are responsible for knowing your policy benefits and the portion you will be liable for.**
2. Not all services are covered under all contracts. Some insurance companies select certain services to be non-covered. Any portion of these fees will be the responsibility of the patient.
3. If your insurance carrier has not paid in full within 45 days of receiving the claim the balance due may become your responsibility.

Regardless of insurance payment, the patient or guardian remains responsible for all financial fees obtained at the time of service. We realize that some balances may not be able to be paid in full at the time of service and we are more than happy to assist you in making payment arrangements.

GENERAL INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS and AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize payment of medical benefits to Dr. Deborah C. Hilton, Dr. A. Taylor Hilton or Dr. Sophia V. Mai for any services rendered to me. I understand I am financially responsible for any amount not covered by my insurance contract. I also authorize release to my insurance company for any information regarding my medical treatment and billing

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made to me or on my behalf to Dr. Deborah C. Hilton, Dr. A. Taylor Hilton or Dr. Sophia V. Mai for any services rendered to me. I authorized their office to furnish any necessary Medical/billing information to the necessary Medicare agency or to supplement insurance agencies as needed to determine benefits to secure payment for services.

By signing this billing and payment policy, I acknowledge that I have accepted financial responsibility. This will remain in effect until it is cancelled in writing.

Patient or Guardian Signature

Date

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INVOLVEMENT IN CARE

Patient Name: _____

Date of Birth: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I hereby request that the following person(s) be allowed to participate in my care or payment-decision process. I understand that this person(s) may be given verbal health or payment information about me if I am unavailable or unable to communicate. Hilton Dermatology and Aesthetics will act on this information until I revoke or amend this authorization in writing. If not previously revoked in writing, this authorization will terminate or expire upon (state the specific date, event, or condition):

If left blank, authorization will expire in two years.

NOTE: This form only addresses the proper procedure for disclosing protected health information to patient-identified individuals. It specifically DOES NOT address the designation of individuals authorized to make treatment decisions on behalf of a patient. Treatment decision authority is limited to the patient or the patient's personal representative.

NAME	RELATIONSHIP	DATE OF BIRTH	PHONE NUMBER

Hilton Dermatology and Aesthetics will make a reasonable effort to provide only the minimum necessary information for the person(s) to make an informed decision.

Patient Signature

Date



ACKNOWLEDGMENT TO NOTICE OF PRIVACY PRACTICE

Hilton Dermatology and Aesthetics will use and disclose your protected health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies regarding your personal health information's that we maintain about you, whether it is previously received about you or information we may receive about you in the future. We will post a copy of our correct notice in our facility.

ABOUT OUR NOTICE OF PRIVATE PRACTICES

We are committed to protecting your protected health information in compliance with the law. The attached Notice of Private Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your protected health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures are not described in this Notice.
- The person to contact for further information about our privacy practices.

I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES.

Patient/Guardian Signature

Date