Basko Dermatology

1331 w. 75TH Street, Unit 402, Naperville, IL 60540
P: 630.596.8045 **F:** 630.590.9634

FINANCIAL AND OFFICE POLICIES

IN-NETWORK INSURANCE

- It is the patient's responsibility to provide Basko Dermatology with accurate and current insurance information.
- It is the patient's responsibility to understand the terms and coverage provided under the insurance plan.
- Basko Dermatology has contract with many but not all insurance plans. It is the patient's responsibility to verify that we participate in patient's individual plan.
- It is the patient's responsibility to obtain and confirm a referral prior to each visit if required to do so by patient's health insurance plan. Please contact your primary care physician if a prior authorization or referral is needed for your visit. If either a prior authorization or referral is required, it must be received by us prior to your visit.

CO-PAYMENTS, DEDUCTIBLES AND CREDIT CARD ON FILE

- For insurance companies that we are contracted with, we will determine your co-payment. All co-payments must be paid upon check-in on the day of service. Failure to collect a required co-payment can constitute insurance fraud.
- Any deductible and out-of-pocket amounts will be the patient's responsibility. If the insurance plan as a high deductible, then the patient may have a high out-of-pocket expense for the medical services rendered. Our office will predetermine the amount that you as a patient are responsible for based on your insurance plan. Co-insurance amounts, deductibles, and all non-covered items and charges are due at the time of service.
- Basko Dermatology requires that you keep a credit card on file with our office to pay any balance due after insurance has paid its portion of your bill. We will send you an invoice and wait 30 days for payment. If payment is not received after 30 days, we reserve the right to charge your credit card for the balance due. We will give you a courtesy phone call prior to charging your credit card (Please see our Credit Card on file policy).
- Non-insured, out of network and patients without a referral (if required by insurer) are required to pay in full at the time of service. If you wish to submit your bill for reimbursement to your insurance company, we are happy to provide you with receipt of payment for your visit as well as a copy of the claim.
- Basko Dermatology reserves the right to end our professional relationship if there are outstanding balances greater than 90 days.

COSMETIC PROCEDURES/PRODUCT PURCHASES

- Charges related to cosmetic/elective procedures and product purchases will be collected at time of service and are non-refundable. Basko Dermatology will not submit charges for non-medically necessary procedures to your insurance company.
- Products sold at Basko Dermatology cannot be returned unless they are defective.

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NO-SHOW AND CANCELLATION POLICY

- Basko Dermatology requires a notice of at least 24 hours to cancel or change an appointment, as this will ensure access for other people in need of an appointment. If you fail to provide sufficient notice multiple times, we may require a deposit to schedule additional appointments or end our professional relationship and ask that you seek care elsewhere.

MINORS

- All minors must be accompanied by a parent or guardian in order to be seen.
- If patient is accompanied by a short-term guardian to their appointment, then you are required to complete the *Illinois Statutory Short Term Form Appointment of Short-Term Guardian*. Please call our office to obtain the form.
- The parent/guardian that signs this Patient Financial Policy will receive the billing statements for the minor and will be responsible for payment on the minor's account, regardless of who is the primary holder of the insurance.

BILLING QUESTIONS

- If you have any questions about your medical bill, please contact us at 630-596-8045 ext. 2. We are happy to review your statement and make sure that it is accurate. Please be advised that medical bills are NOT negotiable.

Insurance Information Release Authorization: I acknowledge that I have reviewed, understand and agree to the financial policy of Basko Dermatology, LLC as stated in this document. I hereby authorize Basko Dermatology to release the medical information to my insurance company to process claims.

Patient (Authorized Representative) Signature: _____ Date: _____

Printed Name of Authorized Representative: _____

Relationship to Patient: _____

Address/Phone Number of Authorized Representative: _____