

BRENTWOOD SKIN CLINIC  
Financial Policy

I (the patient) agree to pay for the services provided AND agree that payment is ultimately MY responsibility and NOT that of my insurance company. I realize that payment of co-pays, deductibles, etc. will be expected at the time of service. I authorize payment for medical services to Dr. Charles Austin Mitchell, M.D. at Brentwood Skin Clinic, PLLC. I agree to pay any and ALL unpaid balances, including but not limited to:

1. The principal balance of my bill
2. Collection charges and fees
3. Returned check fee of \$50

**Insurance:** Brentwood Skin Clinic will file an insurance claim with my PRIMARY insurance carrier but they will NOT file claims with secondary insurances as they do not have individual contracts with those carriers. BSC can provide me with an insurance claim form (IF REQUESTED) for me to submit to my secondary provider. Any balances remaining after payment from my PRIMARY carrier will be MY responsibility.

BSC staff will ask that I present my insurance card on each visit and verify my contact and billing information to make sure everything is up to date.

**Payment:** BSC has numerous ways that I can pay for services. They accept Cash, Credit Card, Apple Pay, Online payment through Stripe or personal check. Personal check will require proper ID (valid Drivers License or other photo ID). A \$30 overdraft charge will be added to any returned check. BSC will only send paper statements if I do not provide a valid e-mail address.

**Collections:** Any delinquent account will be turned over to collections after THREE (3) unpaid statements. Once my account has been turned over to collections I will need to pay in full for any future visit regardless of insurance coverage.

If I am turned over to a collection agency or attorney for collections, the cost of collections, attorney fees and court costs, and any collection agency fees will be my responsibility. BSC will assess a 33.33% collection charge on my balance.

**Credit Card on File:** We do offer the option to securely store your CC on file for any outstanding balances or unpaid fees. This is OPTIONAL. Please inquire at the Front Desk if you would like more information.

**Non-covered Services:** I understand that some, and perhaps all, of the services I receive may not be covered by my insurance or not considered reasonable or necessary by Medicare or other insurers. I understand and agree to pay for any services which have been determined by my insurance plan to be "non-covered". Self pay, Cosmetic or any non-covered services are to be PAID IN FULL at the time of service unless other arrangements have been made directly with Dr. Mitchell.

**Refunds:** The following criteria must be met prior to BSC issuing a patient refund: there are no outstanding insurance claims on my account; there are no outstanding patient balances on my account or my family account.

**Referrals:** Some insurance require a referral from your Primary care physician for specialty services. If this authorization is required but not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Regarding my Health Insurance:

**It is MY responsibility to:**

1. Ensure that BSC is provided with the most current insurance information prior to filing my claim including the primary policy holder, insurance card, ID number, employer, date of birth, and patient address.
2. Ensure BSC is contracted with my insurance carrier to receive benefits.
3. Pay my co-payment and patient portion AT THE TIME OF SERVICE, including any deductibles.
4. Inform BSC of any insurance changes. Insurance carriers have specific timely filing guidelines AND pre-authorization requirement for certain services. If updated insurance information is not provided to BSC within my insurance's timely filing limits, I will be required to pay for services in FULL. If prior authorization was required for services already received and my claim is denied for lack of authorization, I will be required to pay for services in FULL.
5. Contact my insurance company if no Explanation of Benefits (EOB) is received within 45 days of the date of service.

**It is BSC's responsibility to:**

1. Submit a claim to to my health insurance in a timely manner based on the information I provide at the time of service or as updated information is provided.
2. Provide my health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of my insurance card.