

Carolina Skin Surgery Center (CSSC) Office Policies

2615 E. 7th St. Charlotte, NC 28204 ~ Phone: 704-295-0000 ~ Fax: 704-295-0005

Payment: I am aware that insurance is a contract between me and the insurance company and ultimately, I am responsible for payment in full to CSSC. I understand that it is my responsibility to determine if CSSC is a network provider for my insurance carrier. I agree it is my responsibility to understand my insurance benefits and to notify CSSC immediately of any changes to my insurance coverage. I understand that it is my responsibility to obtain insurance authorization if it is required and the payment is still my responsibility. All copays, deductibles, and coinsurance are collected at the time of service. As a courtesy, CSSC will file claims to my primary and secondary carriers for medical services. If an estimate is provided, I understand that this estimate is never a guarantee of the final amount that I may owe. CSSC will not know the final amount until my insurance company processes the claim. I understand I am responsible for any services not covered by my plan.

I agree that if my insurance carrier sends payment to me for the medical services instead of to CSSC, I will immediately pay the amount due to CSSC. I agree for CSSC to service my account or to collect any amounts I owe. I agree I may be contacted by telephone at any number associated with my account, including wireless telephone numbers, which could result in charges to me. I may also receive text messages or emails.

I understand that if my account has not been paid in full within 90 days from the time my insurance responds or Date of Service if I am self-pay, the account may be referred to our collection agency. I understand I will be responsible for all cost including fees, attorney fees, and court fees. CSSC will refund overpayments to the appropriate party within 90 days from the time your insurance responds. Refunds of less than \$5.00 will not be issued unless requested.

Consent for Filing Insurance Claims: I hereby authorize and direct my insurance carrier/Centers for Medicare and Medicaid (CMS) services to issue payment directly to Carolina Skin Surgery Center, PA for medical services rendered to myself and/or my dependents. I authorize the release of any relevant information to my insurance company. I authorize my provider's office to act as my agent in assisting me to obtain payment from my insurance company. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to Medicare assignment of benefits apply. I understand that I am responsible for any amount not covered by insurance.

Medicare: CSSC is a participating provider of the Medicare program. CSSC will accept assignment on all claims. I am responsible for meeting my annual deductible and paying for the 20% coinsurance. CSSC does file with secondary/ supplemental carriers. However, in the event that the secondary does not pay within 60 days, I will be balance billed.

By signing below, I acknowledge I have read and understand the CSSC office policies and accept full responsibility for my account.

Patient Name: _____ **Date:** _____

Patient Signature: _____