Precision Skin Care, LLC.
1709 W. 7th Street
Chanute, KS 66720
620-431-0023

PATIENT PAYMENT POLICY

NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Patient Responsibility: You are responsible for all charges resulting from treatment provided by Precision Skin Care, LLC. We bill most insurance carriers. Your co-payment is always due at the time of service, any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made. If you have a past due balance, we may ask you to make a payment at the time of your next visit with us. Patients under 18 years of age will be the responsibility of the legal guardian(s).

Minor Patients: for all services rendered to minor patients, the parent and/or legal guardian who signs authorization for treatment will be responsible.

Insurance Billings: It is your responsibility, (or that of the financially responsible party) to provide current and accurate insurance billing information. If your insurance information changes, please provide the new insurance information prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges. **It is your responsibility to know your insurance benefits.**

Pathology (Biopsy) Charges: Precision Skin Care, LLC. Will not be able to determine the total cost of your office visit today until we receive your lab report. Your payment may not cover all charges and you will be responsible for any additional charges from our office and/or the lab.

Private Pay: You will be responsible for payment at time of service and prior to any procedures that are scheduled. **If you do not have a current insurance card, you will be responsible for payment in full at the time of your visit.** It is our office policy to charge a $35 fee for checks that are returned.

You are entitled to question any part of your bill that you feel is in error. During the time that a charge is in question, you are not responsible for the payment of the charge in question. You will be responsible for the remaining portion of your bill not in question. Precision Skin Care must receive notice from you no later than 30 days from your first statement in which the error appears. You may call to give notice for any part of your bill that you feel is in error. The charge in question may still appear on your statement; however, until contacted by Precision Skin Care, you will not be responsible for the payment of the charge in question. If the charge is found to be correct, you will be contacted and a statement of your account balance will be reissued.

I hereby authorize payments of benefits to Precision Skin Care. LLC. I understand I am financially responsible for all charges incurred in the course of my treatment by Precision Skin Care, LLC.

I HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS. I CAN REQUEST A COPY OF THIS POLICY AT ANY TIME.

_____	_____	_____
Patient Name (Please Print)	Patient's Signature or Patient's Representative	Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have been offered and or received a copy of the Notice of Privacy Practices.

_____	_____
Signature of Patient or Representative	Date