Thank you for choosing The Idaho Skin Institute for your dermatology health care provider.

The following is a statement of our Financial Policy:

IF YOU HAVE HEALTH INSURANCE COVERAGE:

- You are responsible to supply us with correct current insurance information.
- Please notify us of any change in your address or telephone number.
- All copay's are due at the time of service.
- Referrals are your responsibility and must be current prior to your visit.
- Your estimated portion, including any deductibles, will be expected at the time of service (our business office will notify you in advance if this is required).
- You may not receive a self-pay discount and then ask us to file your insurance at a later date.
- You are ultimately responsible for payment of all charges whether or not such charges are covered & paid (either fully or partially) by your insurance.

IF YOU DO NOT HAVE HEALTH INSURANCE or IF YOU REQUEST A COSMETIC PROCEDURE:

- Payment in full is due at the time of service.
- We accept cash, check, VISA, MC, Discover AE.
- We charge 18% APR on all balances over 90 days.

Our business office is available from 8AM to 4:30 PM Monday thru Thursday and from 8am to noon Friday to answer any questions or address any concerns you may have. If you receive a statement from our office, then we expect payment from you within 30 days. If you disagree with the balance for any reason please contact our business office immediately. **We will no longer carry account balances over 90 days past insurance payment.**

208-238-7546.

A parent who brings a minor child to our office for medical care is responsible for payment of all of the child's charges. Unaccompanied minors will be denied non-emergency treatment unless pre-authorized by parent /guardian.

A $25.00 fee is charged for missed appointments.
A $25 fee is charged for returned checks.

I hereby guarantee payment of all charges for medical treatment and services provided to me (or any dependent) by The Idaho Skin Institute. I understand & agree that if the office places my account with an agency or attorney for collection, the office shall be paid by me for all collection costs to the extent allowed by applicable law.

I HAVE READ AND AGREE TO THIS FINANCIAL POLICY:

_____DATE_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

CREDIT/DEBIT/ACH POLICY

Print Patient Name: _____
Date of Birth_____

I understand it is the policy of The Idaho Skin Institute to secure my credit or debit card information at the time of my visit. The office acknowledges that we must comply with the provisions of the U.S. law.

If, after a claim has been submitted to my insurance carrier: 1) the claim is denied for any reason: or 2) there is patient liability (i.e. deductible, co-insurance, etc.); the office will send a statement notifying me of the balance due. If this amount is not paid within 30 days, then my credit or debit card will be charged for the entire balance owed for treatment of services provided to me or my dependent.

I understand my insurance company will also provide notification of these charges with an explanation of benefits. In the event this amount exceeds $250, the office will provide a courtesy call to my primary number before charging my credit card.

I understand that in the event my credit or debit card has been charged for medical treatment or services and then my insurance carrier subsequently makes payment to the office for those charges, the office will issue a credit to my credit or debit card.

Please circle one of the following:

Visa / MC/ Discover / American Express OR

Checking Account / Saving Account

Last 4 Digits of Card/Account number_____
Expiration Date: _____
Name of Card Holder: _____

I hereby authorize The Idaho Skin Institute and its designated employees to charge my credit/debit card or account as designated above, the patient responsibility and/or denied amount of medical treatment and services provided by the office. The charge will be based on the medical treatment rendered to me (or my dependent) and the usual and customary charges made by the office for such treatment and service. If payment is denied by my credit or debit card company or banking institution, I will pay the entire amount within 30 (thirty) days.

_____Date_____
Cardholder's Signature