CASPER DERMATOLOGY CLINIC

1119 East 3rd Street, Casper, WY 82601
phone: (307) 266-2772 fax: (307) 266-2076

Office hours: Monday - Thursday 7:30 am to 3:40 pm and Friday 7:30 am to 11:40 am
Phone hours: Monday - Thursday 7:20 am to 3:20 pm and Friday 7:20 am to11:40 am

Welcome to Casper Dermatology Clinic

Thank you for choosing Casper Dermatology Clinic for your skin care needs. Please take a moment to review the listed practice policies. Attached is the instruction sheet for logging in to the online patient portal to review and update your patient demographics and medical health history. This step is MANDATORY and must be completed at least 2 business days prior to your scheduled appointment. Please contact our office if have any questions regarding the following information.

New patients and patients who are re-establishing care after 3 years are required to check in 30 minutes prior to your scheduled appointment time. Please bring your current insurance card(s) and a government issued photo ID.

Financial and Office Policies
Your health insurance plan is a contract between you and your insurance company. As a courtesy we will verify insurance eligibility with most plans, however, this is not a guarantee of coverage. It is your responsibility to know your plan benefits, including deductibles, co-insurance, co-payment amount and lab contracts. We will submit a claim to all insurances we are in-network with and to most out of network plans, but we do not share in the contract between you and your insurance plan. It is the insured/patient's responsibility to inform this office if your insurance changes, requires pre-certification or prior authorization of services. The patient/guarantor will be responsible for services denied by insurance due to "Non-Eligible", "Non-covered service" or "Prior-authorization/certification not obtained".

Lab Billing
In order to provide our patients with the highest quality skin pathology services, we send our biopsy specimens to Patient-Focused Diagnostics. We do this ONLY because skin pathology is a very specialized field and an accurate and state of the art diagnosis is critical to your health or the health of your loved one(s). These pathologists have been willing to contract with most insurance providers. If you have a skin biopsy, you will receive an explanation of benefits from your insurance, which may still be pending adjustments. You will receive a bill from the lab following negotiations with your insurance company. We do this as a service to our patients and do not receive any compensation from their services. Please do not hesitate to ask us or your insurance company if you have any questions prior to your procedure. For pathology billing questions please contact **Sagis Billing Services: 1(877)-697-2447.**

In Network Plans: we will determine the co-pay, deductible or co-insurance amount at the time of your visit. These amounts are the patient's responsibility per each person's individual insurance plan. This will be DUE AT THE TIME OF SERVICE. Final balances are determined once insurance has processed all charges.

Out of Network Plans: payment will be due on the day of your visit. As a courtesy, we will submit claims to most out of network plans.

Self-Pay: payment for provided services will be due on the day of your visit.

Non-Covered Services: cosmetic services are not covered by insurance will not be submitted to insurance unless requested. Payment in full is due at the time of service.

*Credit Card on File Policy: If unable to pay for all charges at the time services are provided, a payment plan may be approved with a credit card on file to post your monthly payment(s) for the amount agreed to on the appointed date. Due to the high number of high deductible plans and higher co-insurance benefits we understand the possibility of needing to pay over time. **A card on file is required for payment plans**. *This is a secure option and your credit card

will not be charged if you do not owe anything. Once credit card information is entered or swiped, it is encrypted and cannot be viewed or accessed by our organization.

Returned Payment Fees: all returned checks or chargebacks will be charged a $30 processing fee.

Medicare, Medigap, and Medicaid plans: we will bill Medicare and any secondary to Medicare, and Medicaid insurance for you. You are responsible for your co-pay, deductibles, or co-insurance amounts that are not covered by your plan.

Medicare Advantage plans: while most of these plans follow Medicare guidelines, they are commercial plans that have their own rules. At this time, copays will be collected at the time of service, and we will bill your insurance for the additional charges.

*We are in-network with the following insurance payers: **Banner Aetna, Blue Cross Blue Shield, Cigna, First Choice Health Network for the Big Sky Region, First Choice of The Midwest, Tri Care West, United Healthcare, and VA/TriWest.** It is important to note that all plans vary and it is your responsibility to verify what services your plan allows.
*Payer participation is subject to change. It is the insured/patient's responsibility to verify payer participation prior to your visit.

Referrals: While our office does not require a referral to schedule with us, your insurance may require a referral before seeing a specialist. It is your responsibility to know if your insurance requires this and to obtain or request a referral to be submitted to our office prior to your appointment. If you don't have a referral at your appointment time and it is required for your insurance, your appointment may be rescheduled and you may be charged a missed appointment fee.

Same Day Cancellation / Missed Appointment / Late Arrival policy: It is your responsibility to make note of your scheduled appointment date and time. As a courtesy, our reminder service will call, email or text a reminder of your appointment date and time beginning up to one week prior to your scheduled appointment. One business day notice is required for regular appointment changes and two business days' notice is required for surgery appointment changes. If you miss or fail to keep your appointment, or cancel on the same day, a $50 missed appointment fee may apply. A $20 missed appointment fee may apply to missed light treatment appointments. The fee will be collected prior being able to reschedule another appointment.

New Patients who do not check-in on time to complete their pre-appointment documentation may be rescheduled and may be charged for a missed appointment fee.
Inclement weather or other exceptional circumstances will be taken into consideration, but does not guarantee waiver of fee.

Prescription Refills: please allow 72 hours for prescription refills. We ask that you contact your pharmacy first to request refills, they will fax a request to us with all of the necessary information. We cannot refill prescriptions for patients who have not been seen in the past 12 months.

Minor Policy: All minor patients (under the age of 18) must have a parent or legal guardian present for their initial visit with our practice. Patients who are 16 or older may come alone to appointments if we have a completed authorization on file. Patients who may be brought to appointments by someone other than their parent or legal guardian must have an authorization on file identifying who will be authorized to bring the patient and if the person will be allowed to make medical decisions for the patient.

Divorced Parents of Minor Patients: Our practice will not negotiate financial responsibility between divorced parents. The parent or legal guardian who completes the patient financial agreement will be the guarantor listed in the patient chart. If both parents complete the financial agreement, we will bill the parent who agrees to be the primary guarantor.

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MANDATORY ONLINE PATIENT REGISTRATION AND MEDICAL HEALTH HISTORY

Completing the online Patient Registration and Medical Health History through the HIPAA compliant patient portal is MANDATORY and must be completed at least two business days prior to your scheduled appointment. If you are unable to complete this step, you must contact our office to make other arrangements or your appointment will be cancelled.

Online Patient Health History

You have options for logging into the patient portal. You may the link on our website at **casperdermclinic.com** or download the patient mobile app **APPatient. I**mportant browser reminder: Internet Explorer and Safari are not compatible with the patient portal software and will not allow you to complete the patient portal verification. Please follow the instructions below.

1. If using the URL on your computer, begin by opening your internet browser, either **Google Chrome** or **Mozilla Firefox.** If using your mobile device, download and open **APPatient**.
2. If using a computer, you will type in the web address (URL): **https://casperderm.ema.md**. You will be directed to the **Casper Dermatology Clinic** login page. Select **Patient Login**, on the lower right in the window, then enter the following in the appropriate fields:
3. If using your mobile device, download and open APPatient. enter **casperderm.ema.md,** then the email associated with your medical record and the password that has been assigned to you. If you have not been assigned a password, call the office and we can give you that information over the phone.

Please note this information below for future use.

Username is: _____ **Password is:** _____

Once the portal opens to the landing page, please verify the patient's name and date of birth are correct. If they are not correct, log out immediately and notify our office. If the information is correct you may proceed.

From the landing page, above the purple information bar at the top of the page, select My Health. This will open the first of the categories to be reviewed and updated. Listed below are all required categories:

- Contact Info
- Medications
- Allergies
- Past Medical History (immunizations, flu vaccine, pneumonia vaccine, etc.)
- Skin Disease History
- Social History (smoking, alcohol use, etc.)
- Implantable Devices
- Family Medical History

Some categories may have fields that will not open for you, i.e., insurance. These fields are locked for internal use only. If you see an error in your information, please logout immediately and notify our office. We will promptly correct any errors.

CASPER DERMATOLOGY CLINIC PATIENT REGISTRATION

Patient's Legal Name: Last_____ First_____ Middle Initial____
Nickname: _____ SS#: _____Date of Birth: ____/____/____
Sex: **M / F** Circle one: **Married / Single / Divorced / Widow / Other**
Race: _____ or **Unknown** or **Decline to Specify** Preferred Language: _____
Ethnic Group: **Hispanic or Latino / Not Hispanic or Latino / Decline to Specify / Unknown**
Primary Phone:(_____) _____ Secondary Phone:(_____) _____
Mailing Address: _____ City/State: _____ Zip Code: _____
Email Address: _____ Employer: _____
Please List Your Primary Care Physician: _____
In case of emergency, please contact: Name: _____ Phone: _____
Relationship: _____ May we discuss or provide information about your appointments and/or treatment and care, including pathology results to this person? **Yes / No**
If different than the emergency contact, I authorize Casper Dermatology Clinic to provide information about my appointments and/or my treatment and care, including pathology results to the following person(s). Please list spouse, if applicable.
Name: _____ Relationship: _____ Primary Phone: _____
Name: _____ Relationship: _____ Primary Phone: _____

- I authorize Casper Dermatology Clinic to leave a general voice message, test results and/or appointment reminders on my primary or secondary phone voice mail.
- I authorize Casper Dermatology Clinic to share my medical information as needed for billing and continuity of care.
- I authorize treatment of patient listed above.
- I understand that this authorization will remain in effect until I revoke it in writing by notifying the Privacy Officer at the Casper Dermatology Clinic.
- I understand that I may request a copy of this completed and signed authorization form.
- I authorize Casper Dermatology Clinic to obtain clinical photos from my medical chart for clinical or educational purposes.

Patient or Authorized Signature: _____ Date Signed_____

- I acknowledge that I have been informed that pathology services performed during my appointment(s) will be billed separately by the specialty lab (**Sagis Patient-Focused Diagnostics**) and I will receive a separate bill for these services.

Patient or Authorized Signature: _____ Date Signed_____

*To ensure confidentiality and privacy, any type of electronic recording (audio or video) is strictly prohibited at any location within this office without prior consent. _____ **Patient Initials**

- I acknowledge by signing below that I have received or been given the opportunity to receive a copy of the Casper Dermatology Privacy Practices and Individual Rights.

Patient or Authorized Signature: _____ Date Signed_____

Financial Responsibility

<u>Unless you are insured through Medicare, Medicaid, Kidcare Chip (except for copay), Tricare and VA we ask for payment at the time of service.</u>

Insurance claims will be filed as a courtesy; however, we do NOT file claims to all payers. We file claims to all payers that we are in network with.

Divorced Parents of Patients: Our practice will not negotiate financial responsibility between divorced parents. The parent or legal guardian who completes the patient financial agreement will be the guarantor listed in the patient chart. If both parents complete the financial agreement, we will bill the parent who agrees to be the primary guarantor.

Authorization and Agreement

- I authorize the release of any medical information necessary to process this bill to my insurance company and request payment of benefits to Casper Dermatology Clinic.
- I acknowledge that I have been informed of Casper Dermatology's right to charge a Missed Appointment Fee in the case that I do not show up to my scheduled appointment or do not notify the clinic one business day in advance of the need to cancel or change the date or time.
- I acknowledge that I am financially responsible for payment of services not allowed by insurance, or that my insurance states that I am responsible for (copay, deductible and coinsurance amounts).
- I agree to pay all charges for me and those I have agreed to be the responsible party for at the time of treatment, unless payment arrangements are agreed upon in advance. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney fees and court costs.

Patient or Authorized Signature: _____ Date: _____

Guarantor or Responsible Party Billing Information: (only minor children or person(s) with a legal guardian may have another person(s) financially responsible for billing).

Print Legal Name _____ Relationship to patient: **Self / Parent / Legal Guardian**
Mailing Address: _____ City/State: _____ Zip Code: _____
SS#: _____ DOB: _____/_____/_____ Primary Number: _____
Employer Name: _____ Employer Phone Number: _____

Additional Responsible Party Billing Information (spouse, parent or guardian accepting responsibility in addition to primary responsible party).

Print Legal Name _____ Relationship to patient: **Self / Parent / Legal Guardian**
Mailing Address: _____ City/State: _____ Zip Code: _____
SS#: _____ DOB: ____/_____/_____ Primary Number: _____
Employer Name: _____ Employer Phone Number: _____
Authorized Signature: _____ Date: _____

Primary Insurance Company Name: _____
Mailing Address for Claims: _____
ID#_____ Group#_____ Subscriber Name: _____
Subscriber Date of Birth: M/D/YY _____ Relationship to Patient: _____
Secondary Insurance Company Name: _____
Mailing Address for Claims: _____
ID#_____ Group#_____ Subscriber Name: _____
Subscriber Date of Birth: M/D/YY _____ Relationship to Patient: _____