SUMMIT SKIN & VEIN CARE

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(816) 554-9470 Fax

PATIENT'S / GUARANTOR BILLING & RESPONSIBILITY AGREEMENT

(Initial) _____ I understand that Summit Skin & Vein Care will make every effort possible to verify my benefits with the insurance company information provided by me. I understand it is ultimately my responsibility to understand my benefits and agree to not hold Summit Skin & Vein Care responsible for incorrect benefit information that may be provided to Summit Skin & Vein Care by my insurance company.

(Initial) _____ I understand that, under the terms of the contract with my insurance company, that the co-payment, deductible, and estimated amount of co-insurance must be paid at the time of service.

(Initial) _____ **TRICARE PATIENTS ONLY**: I understand that it is my responsibility to know if Tricare requires a referral for my care. And, if a referral and authorization are required, it is my responsibility to call Tricare prior to each appointment to verify I have a current referral and authorization on file. If a current referral and authorization are not on file at the time of service, I understand the services provided will not be covered by Tricare and I will be billed and payment in full will be due.

(Initial) _____ I understand that Summit Skin & Vein Care will make every effort possible to file my claim(s) in a timely and accurate manner with my insurance company to assist in the payment of my care and I authorize the release of medical information to the insurance company concerning my treatment. If necessary, I authorize Summit Skin & Vein Care to file a complaint, on my behalf, with the appropriate authorities to assist in the payment of my claim(s).

(Initial) _____ I understand that Summit Skin & Vein Care will send a statement for any additional balance due to the address on file after my insurance company has made payment on my behalf. At this time, they will request I pay any balance due within 30 days by cash, check or credit card.

(Initial) _____ I understand that if my insurance claim is denied due to incorrect personal information or incorrect insurance information or an omission of information on my part, I will be responsible for 100% of the dates of service not covered and payment in full will be due immediately

(Initial) _____ I understand if I have no insurance coverage, I agree to pay the balance in full at the time services are provided.

(Initial) _____ A service charge of $25.00 will be assessed on all returned checks or credit transactions.

(Initial) _____ I, Patient / Guarantor, acknowledge and understand that I am financially responsible for all services rendered to me by Summit Skin & Vein Care. Although Summit Skin & Vein Care may bill my insurance company for services on my behalf, I understand that it is still my responsibility to make sure that the bill is paid within a reasonable length of time.

(Initial) _____ I, Patient / Guarantor, understand that multiple patient accounts at the same address, i.e., spouse and / or dependent accounts held within Summit Skin & Vein Care Accounts Receivables are considered as one "Household" account.

(Initial) _____ I, Patient / Guarantor, also understand any credit balances on a patient account within the "Household" may be used for other "Household" accounts until all "Household" accounts are settled and paid in full.

(Initial) _____ If for any reason, there is a balance owing after my insurance company pays, I, Patient / Guarantor, agree to pay the balance within 30 days of being billed. I also understand that if litigation becomes necessary to recoup any balance due to Summit Skin & Vein Care, I will be held liable for any attorney's fees and court cost that are applicable.

By initialing above and signing below, I verify that I have reviewed and understand the information on this form.

Printed Patient Name _____ Date of Birth _____

Patient/Guarantor Signature_____ Date _____