Braddock Finnegan Helget Dermatology, P.C.

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Financial Policy

Thank you for choosing Braddock Finnegan Helget Dermatology, P.C. for your dermatologic care. This document outlines our financial policies to help you understand your responsibilities and our billing procedures. Please read the following information carefully.

1. **Insurance and Patient Responsibility**

As a courtesy, we file insurance claims on your behalf. However, regardless of insurance status, you are ultimately responsible for payment of all services rendered. It is your responsibility to confirm whether your provider is in-network with your insurance plan.

2. **Statements and Payment Timelines**

You will receive a statement showing your "patient balance" after your insurance processes the claim. Payment is due within 15 days of the statement date unless other arrangements are made with our billing office. If you cannot pay in full, please contact us at (402) 390-0333 to discuss a payment plan.

3. **Collections Policy**

Any outstanding "patient balance" that remains 15 days after the third mailed statement will be sent through our collections process. Once in collections, Braddock Finnegan Helget Dermatology P.C. will require the outstanding "patient balance" to be paid in full before scheduling another appointment. You will be required to have a credit card on file and pay a $100 deposit prior to scheduling another appointment. Failure to make any payments for "outstanding balances" in a collections status may result in termination from the practice.

4. **Co-Payments and Deductibles**

Co-pays are due at the time of service. We cannot waive co-pays due to insurance agreements. If you have a remaining deductible, a deposit may be requested prior to treatment.

5. **Self-Pay Patients**

A $200 deposit is due at the time of service. Any balance above $200 will be billed. If charges are under $200, you can choose to be refunded the difference or have the credit balance remain on your account for future services.

6. **Cosmetic Services**

Full payment is due at the time of cosmetic services or product purchases. Cosmetic services are not billed to insurance.

7. **Non-Covered Services**

Some services may be considered non-covered or not medically necessary by insurance. You are financially responsible for these services.

8. **Pathology Services**

You may receive a separate bill for slide processing and/or interpretation. In some cases, a second opinion may be required, which could result in additional charges.

9. **Laboratory Services**

If blood work is performed, a separate bill may come from the laboratory. If your insurance requires a specific lab, you must inform our staff at the time of the draw.

10. **Billing Inquiries**

Please contact us promptly to address any billing questions or errors. Ignoring billing statements or calls may lead to collections, as we assume services were rendered in good faith and payment is expected.

11. **Referrals**

Some insurance plans require a referral from your primary care provider. It is your responsibility to obtain this referral. Without it, you may be responsible for a greater portion of the bill.

12. **Personal Injury Claims & Workers' Compensation**

We do not participate in personal injury litigation including Workers' Compensation. Full payment is required at the time of service, and any reimbursement must be sought by you from your legal settlement and/or workers' compensation.

13. **Accepted Payment Methods & Returned Checks**

A $40 service charge will be applied for any returned checks. We accept cash, checks, all major credit cards including Visa, Mastercard, Discover, and American Express. We also accept most HSA, HRA, and FSA account cards. We **do not** accept CareCredit.

14. **Credit Card on File**

We securely store credit card information using encrypted technology within our electronic medical record system. This policy does not affect your ability to dispute charges or your insurance company's decisions.

Acknowledgment

By signing below, you acknowledge that you have read and understand the financial policy outlined above and agree to the terms.

Patient or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature:_____Date: _____