DENVER SKIN DOCTORS

PATIENT ELECTION TO SELF-PAY FOR SERVICES DESPITE IN-NETWORK INSURANCE

I, (PRINT NAME) _____, the undersigned patient, acknowledge that I understand and agree that:

1. Denver Skin Doctors and its providers are in-network with my health insurance company, _____, referred to as "Company."
2. I am covered by one of the health insurance programs offered by the Company.
3. The health plan under which I am covered includes benefits for some or all of the services provided by Denver Skin Doctors.
4. Despite the above, I do not wish Denver Skin Doctors to submit a claim to my health insurance company for services they have provided to me. I **will not** be provided with a superbill and **I cannot** submit to the Company for reimbursement for any services provided and paid in full _____**Pls initial**
5. The self-pay amount covers only the professional services provided by my physician. I am financially responsible for all ancillary services, for example pathology laboratory services performed by Labcorp. I will receive a separate bill from the responsible party performing these services _____**Pls initial**
6. Until such time as I may otherwise advise Denver Skin Doctors in writing, I elect to pay for all services I receive from Denver Skin Doctors at their self-pay rates.
7. By election to self-pay for services, any payments I make to Denver Skin Doctors will not be credited toward satisfying any deductible that I may be subject to under my health insurance plan unless otherwise permitted under the terms of my health plan_____**Pls initial**
9. I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about it. Any questions I may have had about this form have been answered to my satisfaction.
8. I have freely chosen to self-pay for services after having asked Denver Skin Doctors about payment options and having carefully considered those options.

X_____

Patient-Date

Legal Representative/Guardian required for minors and individuals with disabilities requiring assistance.

X_____

Legal Representative/Guardian – Date

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Self-pay prices for most common procedures

New patient office visit (99203-99204)	$167-253
Follow-up patient office visit (99213-99214)	$114-167
Freezing of precancerous lesions, 1st lesion (17000)	$101
Freezing of precancerous lesions, 2nd-14th lesion (17003)	$9 per lesion
Freezing of precancerous lesions, 15 or more	$236
Freezing of benign growths, up to 14 lesions (17110)	$172
Freezing of benign growths, 15+ (up to 20) (17111)	$203
Shave biopsy, 1st lesion (11102)	$154
Shave biopsy, each additional lesion (11103)	$83
Punch biopsy, 1st lesion (11104)	$193
Punch biopsy, each additional lesion	$95

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This document serves for compliance with HIPAA/HITECH Regulation [Section 13405 of Subtitle D of the HITECH Act (42 USC 17935], which states the following:

Sec. 13405. Restrictions on certain disclosures and sales of health information; accounting of certain protected health information disclosures; access to certain information in electronic format; requested restrictions on certain disclosures of health information.
In the case that under paragraph (a)(1)(i)(A) of section 164.522 of title 45, Code of Federal Regulations, an individual requests that a covered entity restrict the disclosure of the protected health information of the individual, notwithstanding paragraph (a)(1)(ii) of such section, the covered entity must comply with the requested restriction under these circumstances:

o Except as otherwise required by law, the disclosure is to a health plan for the purposes of carrying out payment or health care operations (not for the purposes of carrying out treatment).

o The protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. This means that if you, the patient, do not wish to use your health insurance or med-pay, you can request that your insurance not be billed. A PPO cannot require you, the patient, to file a claim.
However, we require clients who select this option to complete the following attestation requesting the restriction.

Full act:
https://www.healthit.gov/sites/default/files/hitech_act_excerpt_from_arra_with_index.pdf