



Braun Dermatology

Mohs Surgery / Medical and Cosmetic Dermatology

Martin A. Braun, M.D. / Alicia D. Braun, M.D. /

Marisa A. Braun, M.D./ Zetta Hester, M.D. Chelsey Huffman, M.D.

Joseph Hudson, PA-C / Gina DeBlasio, PA-C/ Emma Yohannan, PA-C

Office Policy for Braun Dermatology (BD)

(Revised January 2024)

*****Please initial each policy*****

Financial Responsibilities

___ I understand and agree that payment of authorized benefits under my insurance carrier(s) will be made to my provider for any covered services rendered at Braun Dermatology.

___ Braun Dermatology (BD) typically verifies insurance coverage as a courtesy, but you or your legal representative are ultimately responsible for understanding the details of your insurance plan regarding copays, co-insurance, or deductibles for any visits or procedures you schedule with us. You are fully financially responsible for any balance resulting from your care at BD

___ It is the patient's responsibility to provide BD with accurate and updated contact information, mailing address, and insurance information. If no insurance information is provided, or the information is inaccurate, you will be considered a self-pay patient for the services provided that day.

___ To make managing payments easier for both our patients and staff, we have implemented a credit card on file system. Modernizing Medicine Inc., our PCI compliant credit card processing vendor & medical record system will store your card information on a secure and encrypted site. Once your insurance has paid their portion, any remaining balance due will be charged to the card on file and a receipt will be emailed to you. **A valid credit card, debit card, HSA or FSA card will be accepted. I (we), the undersigned, authorize and request that BD charge my card on file for the balance due that my health plan has identified as my financial responsibility.** This authorization relates to all charges not covered by my insurance company for services provided to me by BD. This authorization will remain in effect until revoked by me in writing.

___ Our office sends skin samples to independent dermatopathology labs after biopsies and surgeries. We also send other specimens such as bacterial cultures to independent labs. These labs will charge your insurance separately. We will always try to send specimens to a lab that has a contract with your insurance, however it is ultimately your responsibility to know which labs are preferred by your insurance company. Any charge from the lab will be the patient's responsibility and any questions regarding that bill must be addressed by that patient with the lab or with their insurance company.



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___ Some treatments are not covered by insurance. If BD knows with certainty that the treatment (such as removal of benign growths) is not covered, the patient will be informed of the cost and payment will be due at the time of service. If a treatment is billed to insurance, and the insurance declines to pay for that treatment, the patient will be responsible for payment and will be billed.

___ BD will mail a statement to patients who have any outstanding balances. Payments are due upon receipt of this statement, and can be paid online at braundermatology.com ("make a payment" link), a phone call to give our staff credit card information, or via check mailed to our office. Any outstanding balances older than 90 days may be sent to a collection agency, in which case the patient is responsible for their balance and the agency's collection fee. Failure to pay outstanding balances may also result in discharge from our practice.

Consent to Treat

___ I voluntarily consent to care and treatment as the providers at BD deem necessary or recommend in their professional judgment. My consent includes but is not limited to medical examinations, surgical procedures, diagnostic testing, and laboratory testing.

Appointments

___ Patients must provide ID and proof of insurance at each visit.

___ **All patients are asked to arrive 15 minutes before their scheduled appointment**, so the check-in process is complete before the appointment time. Any patient arriving late may be asked to reschedule, or may be seen as a work-in later in the day. Our providers strive to run on time, and we ask our patients' cooperation towards that goal.

___ If you cannot make your scheduled medical appointment, **you must cancel at least 24 hours (one business day) before the appointment time. Failure to do so will result in a \$55.00 NO SHOW/LATE CANCELATION FEE.** While BD tries to send courtesy appointment reminders via email/text/phone call, it is ultimately your responsibility to remember and keep the appointment. If you have been charged a no show/cancellation fee and believe that you have extenuating circumstances (sudden illness or accident) and would like to explain, please send a letter of appeal to either location (ATTN: Canceled Appointments) to include a doctor's note/police report or supporting documentation.



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___ **MOHS SURGERY:** If you cannot make your scheduled medical appointment, **you must cancel at least 48 hours (two business day) before the appointment time. Failure to do so will result in a \$250.00 NO SHOW/LATE CANCELTION FEE.**

___ In a one year period, if a patient misses an appointment (or cancels with less than 24 hours notice) three times, the patient will be automatically discharged from the practice. For new patients, two missed/last minute cancellations will lead to discharge.

___ Full payment for all **cosmetic** procedures are due at the time of service. The company will not hold a deposit fee for cosmetic procedures and or encounters. This applies but is not limited to (**Coolsculpting, Ultherapy, Fractora, Morpheus 8, Miradry, Sculptra, Botox, Dysport, Juvederm, Restylane, Radiesse, Voluma, Belotero, IPL, Microneedling, Chemical peels, Aerolase**). When scheduling a cosmetic procedure and or consult, Braun Dermatology will hold a credit card on file in your account for any cosmetic appointments. If you fail to give **48 hour notice of cancellation** for any cosmetic procedure, it will result in a **\$250.00** cosmetic “**NO SHOW FEE**” that will be charged to the credit card on file, regardless of circumstances. If a refund on a cosmetic procedure is requested more than 48 hours after booking, there is a **\$75 processing fee.**

Communication

___ While your provider or BD staff member will typically communicate biopsy/lab results to you within 2 weeks, sometimes there are delays. If you have not been notified of biopsy results within 2 weeks, please call our office. If you have had bloodwork done outside our office, it is your responsibility to notify BD when and where you had the tests drawn, as Quest/LabCorp do not always send results automatically or in a timely manner.

___ I understand that BD may contact me using phone calls (live or automated), emails, or text messaging. These communications may serve as appointment reminders, or may be used to give test results, treatment recommendations, outstanding balances, or other information.

___ In the interest of patient privacy and efficiency we encourage all patients to use our secure patient portal for communications and test results. An account can be set up at braundermatology.ema.md.

Medical Records

___ I authorize Braun Dermatology to release any medical or other information requested by my insurance company if necessary to process an insurance claim or determine medication coverage.

3301 New Mexico Ave NW, Suite 301
Washington DC, 20016
Phone: (202) 293-7618 Fax: (202) 775-1772

5911 Kingstowne Village Parkway, Suite 100 & 230
Alexandria, VA 22315
Phone: (571) 302-5377 Fax: (571) 384-6327

www.braundermatology.com



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___ Patients may use the portal to obtain copies of their medical records. If the office is asked to provide those copies, there will be a fee (for patients, \$10 for the first 20 pages then \$0.10 for every additional page). If an outside source (such as an employer) requests records, the fee will be \$55.

___ I consent/do not consent (circle) to voicemails being left on my phone number of choice_(_____)_____ with my protected health information.

Policy on treatment of Braun Dermatology staff and providers.

We understand that these are difficult times and that patients may be dealing with numerous stressors in their lives aside from their skin concerns. In order to maintain a healthy and non-toxic work environment, we do require that patients treat our staff and providers with the same respect and courtesy that they receive from us. We recognize that there might be frustration stemming from scheduling issues such as longer than ideal wait times for appointments, rescheduling due to staff illness or inability to see providers due to shift in scope of practice. There may be dissatisfaction due to technical difficulties with our portal or delay in return of messages for non-urgent issues. As with many medical practices since the start of the pandemic, we are dealing with staff shortages which can lead to delays in call backs and longer hold times.

The staff and providers are doing their best to provide excellent care and service for each patient, in the face of these numerous limitations. We are actively working on improving all these things. We ask for your patience and understanding. We are interested in any constructive feedback that might help us improve the practice. This can be done verbally with our office manager, through our individual surveys that are sent to each patient after their visit with us or in a written letter. We do read them and are continually trying to improve our practice.

___ Braun Dermatology will NOT tolerate mistreatment of staff and providers, to include yelling, belligerent, aggressive or threatening language. We will also not tolerate online bullying with reviews that are slanderous and untrue. For the mental health and safety of our staff, any patients that mistreat our staff and providers will be discharged from the practice.

___ **I acknowledge that I have fully read and understand the office policies listed above. I agree to terms and conditions in this document. All questions and concerns regarding office policies have been addressed and answered to my satisfaction.**

Patient (or guardian/agent) signature _____

Date _____

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**Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain patient rights regarding my protected health information.

I understand that Braun Dermatology & Skin Cancer Center P.C.. may use or disclose my protected health information for treatment, payment, or health care operations—which means for providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other use or disclosure of this information without my authorization.

Braun Dermatology & Skin Cancer Center P.C. has a detailed document called the ‘**Notice of Privacy Practices**’. It contains a more complete description of my rights to privacy and how the office may use and disclose protected health information.

I understand that I have the right to read the ‘Notice’ before signing this agreement. If I ask, Braun Dermatology & Skin Cancer Center P.C. will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review the Notice of Privacy Practices and that I agree to allow Braun Dermatology & Skin Cancer Center P.C. to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Braun Dermatology & Skin Cancer Center P.C. has taken action relying on this consent.

Patient Name (please print)

Date

Signature (Patient or Legal Custodian / Authorized Representative)

Relationship (if signed by another party)

My health information may be discussed with: _____

Name/Relationship

My health information may NOT be discussed with: _____

Name/Relationship

MR# _____ (OFFICE USE ONLY)

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