Center for Dermatology
AND LASER SURGERY

PATIENT FINANCIAL POLICY

Self Pay: All self pay patients without insurance will be asked to pay their balance in full at time of visit. Payment made in full at time of visit will receive a 20% discount. If you are unable to pay in full at the visit a deposit of $206 for new patients and $139 for established patients is *required.* All additional charges will be billed directly to you with payment due in full within 30 days from date of service.

Insurances: Patients are required to bring their current insurance identification card to *each* appointment. It is your responsibility to inform us of any changes in insurance, address, or telephone number. If no insurance card is present and needed at the time of your visit you will be charged the $206 deposit for new patients or $139 deposit for established patients.

HMO/PPO Plans: HMO/PPO co-payments are due at the time of each visit. If a co-payment is not received at the time of your visit there will be a $20 billing fee added to your account. You will be responsible for paying your annual deductible, co-insurance, co-payment and charges for all non-covered services. **If your insurance requires a referral, please call your primary care physician to obtain one prior to your visit. Without a referral, you will be asked to reschedule your appointment.

Medicare: We accept Medicare assignment and will bill your secondary insurance for you. You are responsible for paying your deductible, co-pay, co-insurance, and any amount not paid by Medicare or your secondary insurance.

Commercial Plans: Patients who are covered by a private plan in which our physicians are not providers will be required to pay a $206 deposit for new patients and $139 for established patients at the time of service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Cosmetic Appointments and Product Purchase: We accept cash or card only-no checks please. Checks ok for medical services only.

Cancellation Policy: Our goal is to provide quality dermatological care in a timely manner. We have implemented an appointment/cancellation policy which enables us to better utilize available appointments for our patients in need of dermatological care. **Failure to cancel your appointment without 24 hour notice is considered a "no show". No shows will be billed $100 for an office visit/cosmetic visit and $150 for a surgery appointment. This will not be billed to your insurance and is patient's responsibility. We reserve the right to dismiss patients from our practice after 3 missed appointments in a 12 month period.

Returned Check: In the event we receive a returned check due to insufficient funds, *a $35.00 check fee will be charged* to your account. Payment will be due in full immediately upon notification.

Collection Agency Fee: If your account balance is turned over to an outside collection agency *A $25 processing fee will be charged* to your account.

IMPORTANT NOTE ABOUT YOUR INSURANCE BENEFITS:
Please be sure to check your insurance benefits. Treatments and procedures recommended for you are considered by your insurance company as a separate charge from the office visit with the physician, even if the appointment occurs on the same day as your appointment with the physician. Usually, co-pays and deductibles apply to these types of appointments. For specific questions regarding your insurance policy guidelines, please contact your carrier's customer service department. As a courtesy, our office may contact your insurance to verify coverage on your behalf for specific procedures done in our office. Please note that the quote will come directly from your insurance company and The Center for Dermatology and Laser Surgery is in no way responsible for any misinformation given by your insurance company.

I have read and agree to abide by the policies set forth in this document.

Patient Printed Name: _____ Date of Birth ____/_____/_____

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Responsible Party Printed Name: (if patient is under 18 yrs old) _____

_____ _____/_____/_____

Patient or Responsible Party Signature **Date**