Advanced dermatology & skin care

FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

If we do not have a contractual agreement with your insurance company, payment for services is due at the time services are rendered. We accept cash, check, and credit card payments.

PLEASE NOTE THAT THIS OFFICE DOES <u>NOT</u> PARTICIPATE WITH MEDICAID AND INITIAL HERE: ☐

Returned checks, and balances older than 90 days may be subject to additional collection fees. **Skin care products must be returned within 90 days of purchase for reimbursement.**

Appointments must be cancelled with 24 hours advance notice. Failure to do so will result in a no-show fee as follows: $50.00 for every 15 minutes of general dermatology time and $100.00 for every 15 minutes of cosmetic time scheduled.

We will gladly discuss proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. If you have an indemnity plan, your insurance is a contract between you, your employer (if applicable), and the insurance company.

2. Our fees are generally considered to fall within acceptable range by most companies; they are covered up to the maximum allowances determined by each carrier. Thus, our fees are considered to be usual and customary by most companies. This statement does not apply to companies who reimburse on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

4. All co-payments are to be made at the time of service.

5. If your insurance is an HMO/POS, you are responsible to supply this office with the referral and/or authorization forms PRIOR to being examined. **YOU CANNOT BE SEEN WITHOUT A REFERRAL.**

6. You are responsible for informing us of any changes in your insurance plan or policy. Failure to do so may result in denial of coverage, and you will be held responsible for the fees.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable, to which I am entitled, including Medicare, Private Insurance, and any other health plans to the above named providers.

We must emphasize that as health care providers we are dedicated to providing the best treatment for our patients. We will do our best in the filing of insurance claims; however**, all charges are your responsibility from the date services are rendered.**

Thank you for understanding our Office Financial Policy. If you have any questions, please call and our billing staff will be happy to assist you.

I (**please print name**) _____ have read the Office Financial Policy of Advanced Dermatology & Skin Care, and I understand and agree to abide by this policy.

_____ _____

Signature of Patient or Guardian **Date**