

Patient Name: _____ Account # _____

PRACTICE FINANCIAL POLICY

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding payment guidelines, our staff is trained to consistently inform you of the financial policies of our office.

PROVIDING QUALITY MEDICAL CARE FOR OUR PATIENTS IS OUR PRIMARY CONCERN. We will be more than happy to provide that care within the guidelines of your contract with your insurance company; however, it is your responsibility to understand your benefits and to call your insurance company for clarification of questions relating to your coverage. Payment for non-covered charges and balances not paid by your insurance company is ultimately your responsibility.

Please read and initial each policy below:

As a courtesy, we will obtain in-office benefits for patients with whom our providers are Preferred Providers (contracted health plans). Once these benefits have been determined, payment of any co-pays, annual deductibles, co-insurances and/or non-covered or cosmetic procedures is required at the time services are rendered. _____ Initials

HMO patients and some managed care patients are responsible for obtaining the necessary referrals prior to their appointment. Please call your insurance company to determine if a referral is required from your Primary Care Physician. Appointments may be rescheduled if our office does not receive the required referral by the time of your visit. In addition, unauthorized (referrals not obtained) and non-covered services are the patient's responsibility and full payment for these services are expected at the time of visit. _____ Initials

Patients with health insurance with whom our providers are not contracted with are expected to pay for the full charges at the time of the visit. An Attending Physicians' Statement will be provided to you to submit to your insurance company for reimbursement. We do not file insurance claims for non-contracted health plans. This includes non-contracted secondary plans as well. _____ Initials

If a small sample of growth on your skin is removed, your sample may be sent to our dermapathologist, Dr. Howard Gerber, or an independent pathologist, who examines the sample under a microscope and determines the type of growth or disease present. This helps your provider determine the best possible treatment for you. Thus, there may be a pathology charge for preparation and evaluation of the tissue sample, in addition to your provider's charge for removal of the tissue. _____ Initials

Patients requesting an appointment for cosmetic, vein, surgery or laser appointments will be required to put a credit card on file or pay a \$150 deposit when making an appointment. This deposit will be applied to the total treatment cost and is non-refundable should the patient fail to cancel their appointment 24 hours in advance of the scheduled appointment or does not show for the appointment. _____ Initials

There will be a \$50.00 charge for missed medical appointments or medical appointments not canceled within 24 hours of appointment time. _____ Initials

There will be a \$35.00 surcharge for all checks written and returned by the bank due to insufficient funds. _____ Initials

With your cooperation, you should be able to receive all the benefits offered to you by your insurance plan, allowing us to do what we do best – concentrating on your dermatological needs.

I UNDERSTAND AND AM WILLING TO COMPLY WITH THE ABOVE POLICIES.

Patient Signature

Date