Skin Solutions
DERMATOLOGY

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# FINANCIAL POLICY STATEMENT

Thank you for choosing Skin Solutions Dermatology for your dermatological care. In order to minimize confusion and misunderstanding between our patients and the practice, we have adapted the following financial policies. We are dedicated to providing you with the best possible care and services and we regard you complete understanding of you financial responsibilities as an essential element of your care and treatment.

## GENERAL

We are enrolled in numerous insurance programs and while we are pleased to provide this service to you, it is extremely difficult for us to keep up to date with all the specific and various requirements of each and every plan without your co-operation. Please understand that each plan has different stipulations such as deductibles, co-payments, co-insurances, referral, authorizations, lab work, medications, etc. It is very important that you, the patient, come into our office with all the required documentation and be fully aware of how your plan works prior to your appointment. You, the patient, are the policy holder and it is your responsibility to know the details of your insurance plan. Al co-payments ae dur prior to seeing the physician on the day of the visit.

## LABORATORY

Depending on your insurance carrier's policy, you may be required to pay a separate payment for any specimen taken during your visit.

## COSMETIC/SELF PAY PATIENTS

Payment is due at the time of service.

## NO SHOW RESCHEDULING FEE

**A charge of $25 will be applied for any appointment that is not cancelled or rescheduled with more than 24 hours notice.**

## COLLECTIONS

In the event that any action is brought to collection, I agree to pay any reasonable collections costs and/or attorney fees. My signature below indicates my understanding and full responsibility for the balance on my account for any professional services rendered at Skin Solutions Dermatology PC.

## BENEFIT ASSIGNMENT

I hereby authorize the assignment of benefits (payments) directly to Skin Solutions Dermatology, PC for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance company. I understand that copayments, deductibles and non covered services are due in fill at the time of service.

## RECORDS RELEASE

I authorize the release of any medical information necessary for the purposes of processing claims with my insurance company. I permit a copy of this authorization to b used in place to the original

Signature of Responsible Party: ______________________________ Date: ____/____/____

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## DEDUCTIBLES AND CO-INSURANCE

Payments can be made by cash, Visa, or Master-Card. Patient balances are due immediately upon receipt of statement. In order to facilitate timely payment of balances due we ask that you provide us with your credit card or HSA information.

I authorize Skin Solutions Dermatology, P.C: to charge my credit/debit/HSA card for the total patient responsibility amount listed on the EOB, but not exceeding $300 (three hundred dollars) and/or $25 (twenty five) for any appointments missed or not cancelled with less than 24 hours notice. If I feel the patient responsibility portion listed on the EOB is inaccurate, I must resolve this directly with my insurance company. Any change in the EOB by the insurance company will be reflected as a credit or additional charge to the account on file.

Patient Name: ______________________________

Credit/Debit/HSA Card number: ______________________________

Expiration Date: ________________ Security Code: ________________ Zip Code: ____________