



We reserve the right to
change this Policy.

Any revised Policy will
be posted in our waiting room.
Upon request we will provide you
a copy of a revised Policy.



Patient Financial
Responsibility Policy

Welcome to Dermatology Associates, P.A.

The following information outlines financial responsibilities related to payment for professional services.

Forms of Accepted Payment

Dermatology Associates accepts Visa, MasterCard, American Express and Discover credit cards, personal checks and cash. You will be given a receipt for payments.

Participating Insurance Plans

Dermatology Associates participates with most insurance plans. Please note the following:

1. Bring your insurance card(s) and picture ID to every visit.
2. You are expected to pay your co-pay at each visit.
3. Your co-pay applies to the office visit only. Dermatology Associates is contracted with many insurance plans to provide services for negotiated rates. We send bills to you for services that your plan defines as amounts you owe.
4. Co-payments, co-insurance, and deductibles are a contract responsibility between you and your insurance plan. We are unable to negotiate or reduce these amounts.

Additional Treatment Charges

If you have a biopsy taken, there are two separate charges for this service:

1. The first charge is a provider/physician charge for collecting the biopsy. This is added to your charges for the day you are seen in the office.
2. Second, there is a charge for evaluating specimen microscopically to determine a diagnosis. This charge may come from Dermatology Associates or a pathology lab. In unusual circumstances, some biopsy specimen(s) need additional laboratory processing or special staining. This is done at the discretion of the pathology provider. These specimens will be sent to a specialized pathology service and you will receive a separate bill for this service.

If a procedure is performed that requires a separate CPT code (such as LN freezing, cautery, wart treatment, surgery, etc.) there will be a separate fee.

Skin tag removals are often not covered by

insurance plans and are considered cosmetic services. The patient is responsible for these charges.

Insurance Deductible

Your insurance plan probably includes an amount for your deductible. You will be responsible for any deductible amount. Dermatology services that are applied to your deductible may include office visits, lesion removal, biopsies, injections, and laboratory. We are unable to negotiate or reduce these amounts.

Treatment of a Minor

If the patient is a minor (under 18 years of age), the parent, guardian, or guarantor must sign below. The parent, guardian, or guarantor is responsible for any payment due at the time of services, and providing required referrals, insurance information and picture IDs. For patients 18-26 years old who remain covered under a parent or guardian's plan, we can only discuss billing information with a parent, guardian, or subscriber. It is only with the 18-26 year old patient's authorization can we discuss medical information with a named individual.

NSF Checks

Checks returned for non-sufficient funds will be handled by Checktek for collection. The fees associated with returned checks are paid to Checktek by the patient or responsible party.

Payment Arrangements & Past Due Accounts

We understand that financial difficulty may be a reality. Payment arrangements can be arranged if needed by contacting our Billing and Insurance Department. Any patient with a past due account may be denied a future appointment until the balance is paid or payment arrangements are made.

Collection Agency

We will not schedule any type of future appointment for you if your account has become delinquent, turned over to a collection agency, or has a bad debt write off. You must pay any amounts due prior to scheduling an appointment.

When an account remains unpaid, a collection agency may be chosen to manage delinquent accounts.

Patient Financial Responsibility Statement

I understand that it is my responsibility to provide current, up-to-date insurance information prior to treatment. I also acknowledge that the filing of insurance claim(s) is **not a guarantee of payment**, and that **I am financially responsible for payment** if such claim(s) are unpaid. I authorize payment of medical benefits directly to Dermatology Associates, P.A., for services provided to me. A copy of this authorization shall be considered as valid as the original. I authorize Dermatology Associates to **fax** my records to any physician or pharmacy for the purpose of coordinating or managing my healthcare.

For cosmetic services not covered by health insurance, I understand that charges are payable on or before the day of service. I understand that I am ultimately responsible for payment of services rendered not covered by my insurance plan and acknowledge that I have read this information.

If you have questions about your insurance or this document, our Insurance and Billing Department will help you. However, specific coverage issues should be directed to your insurance company member services department (typically their phone number is found on the insurance card). If your insurance changes during your course of treatment, please notify us immediately.

I have read and fully understand the Patient Financial Responsibility Policy.

Patient / Guardian / Guarantor Signature

Printed Name

Date