

## FINANCIAL POLICY

Thank you for choosing us as your dermatology specialists. We are committed to your treatment success. The following is a statement of our Financial Policy, which we require you to read and sign prior to receiving any treatment.

**Forms of payment.** We accept cash, check, Visa, American Express, Discover and MasterCard.

**Your part of balances are due at the time of service.** If you have a self-pay (no insurance) or cosmetic (not medically necessary) appointment, your balance is due at the time of service. Co-pays required by your insurance policy are due at the time of service. If you or any of your family members have an outstanding balance, we may ask if you would like to pay this balance at the time of service, as an optional convenience.

**We bill your insurance as a courtesy, but you are ultimately responsible for payment.** Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. You are responsible for understanding how your insurance works. If your insurance denies a claim due to inaccurate or incomplete information you have provided to either us or them, we may bill you directly for the unpaid balances. We are not obligated to wait for you to resolve a dispute with your insurance company before seeking payment from you. We will ordinarily help you as best we can to get proper and timely payment from your insurance, but we do this out of courtesy, not out of obligation.

**Usual and customary rates for non-contracted insurance carriers.** If we have a contract with your insurance carrier, then the maximum financial responsibility of you and your insurance carrier combined is determined by our contract with them as the "allowable fee" for the specific services rendered. However, if we do not have a contract with your insurance carrier, then the total financial responsibility is determined by our prices for the services rendered.

**Minor patients.** A parent or legal guardian must accompany minors at the time of initial visit, and this person becomes the responsible party. Unaccompanied minors at subsequent visits are still expected to make co-payments and to update any changes to patient or insurance information. If parents are separated or divorced, and the parents share financial or insurance responsibility for the minor, then accurate information for both parents is required at the time of service, as is written consent from any responsible parents not present. In the event of any disputes, the parent or guardian who accompanied the minor at the initial visit bears responsibility for outstanding balances.

**Missed appointment fees.** If you cancel or reschedule an appointment within less than 24 hours of the appointment time, or if you miss an appointment, we may add a \$75 fee to your account, depending upon the circumstances and our best judgment about your reliability in keeping past appointments.

**Returned check fees.** If your check is returned by our bank due to insufficient funds in your account, we will add a \$25 fee to your account.

**Accounts receivable.** Please pay your bill promptly or call us at your earliest convenience if you have any questions about your balances due. Our general policy is that balances that have been due for more than 120 days (starting from the date when the claim was sent to insurance, if you have insurance) may be subject to finances charges and may be sent to collections at any time. In virtually all cases we will attempt to contact you as a courtesy before we take these measures, though we are not technically obligated to do so.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. We can provide an additional photocopy of this document if you would like take it home with you.

**My signature below indicates that I have read, understand, and agree to this Financial Policy.**

X

\_\_\_\_\_  
Adult Patient or Responsible Party Signature

\_\_\_\_\_  
Date

We now have the ability to save credit, debit and HSA cards on file to use for any future payments, copays or small balances on your account. Would you like to save a card on file?    **Yes** \_\_\_\_ **No** \_\_\_\_  
If yes, please provide the front desk staff with your preferred card information.

**PLEASE SHOW INSURANCE CARDS TO FRONT DESK STAFF WHEN DONE. THANK YOU!**

**ONCE COMPLETED, PLEASE EMAIL FORM TO: CONTACTUS@ADVANCEDERMNW.COM**