OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any medical services being rendered.

1. FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS WE HAVE A CONTRACT WITH YOUR INSURANCE COMPANY.
2. WE ACCEPT CASH, CHECKS, VISA, AMERICAN EXPRESS, MASTERCARD AND DISCOVER.
3. WE OFFER AN EXTENDED PAYMENT PLAN FOR SURGERIES WITH PRIOR APPROVAL FROM OUR OFFICE MANAGER.

Regarding Insurance:

We may or may not accept assignment of your insurance benefits. If assignment is taken, you will still be responsible for any deductibles or copayments at the time services are rendered. Your insurance policy is a contract between you and your company; we are not a party to that contract unless we also have a contract with your company. If your insurance company has not paid on your claim within 45 days, you will automatically be responsible for the balance.

Please be aware that some, and perhaps all, of the services provided may be deemed non-covered services or not medically necessary under Medicare and/or other medical insurance programs.

Regarding insurance plans where we are a participating provider, all copayments and deductibles are due at the time services are rendered. In the event your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraphs.

Usual and Customary Rates:

Our practice is committed to providing the best treatment to our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. The only exception to this policy is a plan where we are a contracted participating provider.

Missed Appointments/ No-Shows:

Unless cancelled at least 24 hours in advance, missed routine appointments will be charged a no-show rate of $50.00 and missed surgical appointments will be charged a no-show rate of $150.00 for the second no-show, and any no-show after.

Minor Patients:

The adult parent accompanying the minor is responsible for payment of the minor's patient's account regardless of who the insurance policyholder is. For unaccompanied minors, non-emergency treatment will be denied unless the minor is prepared to pay when services are rendered.

I authorize Central Dermatology Center, P.A. to release my information, including the diagnosis and records of any treatment(s) or examination(s) rendered to me or my child, to my insurance company(s) necessary to process claims. I also authorize and request my insurance company(s) to make payment of any medical benefits directly to the physician or Central Dermatology Center, P.A.

THANK YOU FOR UNDERSTANDING THE NECESSITY OF OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THE ABOVE FINANCIAL POLICY.

I HAVE READ, UNDERSTAND, AND AGREE TO THIS FINANCIAL POLICY.

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Signature of patient (If patient is under 18, a parent or guardian must sign. If the patient is over 18, they may sign for themselves.) **Date**

Updated 09/09/2020