Advanced Dermatology Associates
Patient Financial Policy

It is the patient's responsibility to contact their insurance company to confirm that our practice participates with said insurance company, to know their copay obligations for Specialists visits and to know their plan's deductible, and referral policies for Specialist visits.

If your insurance carrier requires you to have a referral to see the Specialist, it is the patient's responsibility to obtain a referral to our office from their Primary Care Physician **prior** to their visit date. If the referral is not in place **with the insurance carrier** on the date of visit, the patient will be given two options:

1) Sign a referral waiver and pay for the scheduled visit out-of-pocket.
2) Reschedule the appointment.

We recommend that you contact your insurance carrier prior to your appointment to confirm your visit has been authorized.

Co-payments are due at the date of service, no exceptions. Also it is the patient's responsibility to accurately know his or her own co-payment amount. For our patient's convenience, we accept Visa, MasterCard, personal check and cash.

All cosmetic procedures or self-pay procedures are payable at the time of visit. Payment can be made by cash, check or credit card.

Returned checks are subject to a $25.00 service charge.

If the patient has an appointment and does not cancel 24 hours in advance to the scheduled appointment or does not show, the patient will be charged $25.00.

***** We use an outside Pathology Lab; the patient is responsible for any charges from that lab that are not covered by your insurance. It is the policy of Advanced Dermatology Associates to send all lesions removed, whether for medical or cosmetic purposes, to the pathology lab for testing. *****

AS A COURTESY TO YOU, we will file your insurance claim. It is your responsibility to see that your insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company. If you fail to pay your bill this could result in turning your account over to a collection agency. It is understood and agreed that in the event any outstanding balance has to be referred to a collection agency or attorney for recovery, you will be held responsible for all collection agency fees and/or attorney fees.

_____ _____ _____

Responsible Party Signature Date of birth Date

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Patient Name_____ Date of birth_____

PATIENTS READ AND SIGN AGREEMENT

1. I hereby give consent for the providers of Advanced Dermatology Associates to evaluate and treat the above patient.
2. I am aware that the Privacy Practice Notice is available at my request.
3. I understand that my personal health information will be used for the purpose of treatment, payment and coordination of health care needs of the patient.
4. I also have been provided and agree with the Financial Policy of Advanced Dermatology Associates.

_____ _____

Responsible Party Signature Date

CONSENT
(if applicable)

*I give my consent for Advanced Dermatology Associates to discuss **payment** for my medical care with the following people:*

_____

Name/relationship/phone number

_____

Name/relationship/phone number