

## **FINANCIAL POLICY**

*Our goal is to help you achieve and maintain optimum health for a lifetime. So that we may better serve you, please read and sign this form. We appreciate the confidence you have place in us as professionals.*

### **INSURANCE PLANS ACCEPTED**

We accept most insurance plans. Most insurance plans have policies that require co-payment at the time of service. YOU are responsible for payment of all co-pays and any outstanding balances at the time of visit. If you are covered under an HMO or other managed care plan (PPO or Point of Service), there may be specific coverage limitation. You are responsible for services that are not covered by your insurance plan. A \$35 fee will be added to your account for any check returned from insufficient funds. \_\_\_\_\_ (INITIAL)

### **BILLING INSURANCE**

Advanced Dermatology Center will make every effort to accurately bill the insurance company with the information you have provided. Occasionally delays occur in claims processing and we may need to contact you for additional information. However, Advanced Dermatology Center does not participate in all insurance companies. It is your responsibility to contact your insurance carrier to verify if the practice group are seeing is a participating provider. \_\_\_\_\_ (INITIAL)

### **NON-COVERED AND COVERED SERVICES**

It is the patient's responsibility to understand which services are covered and not covered under your plan. Some services provided may be non-covered and will ultimately be the patient's responsibility if the non-covered services have been performed. Any procedure, injection, or additional testing can result in additional expenses. Lab tests and/or pathology specimens are sent to outside laboratories will be billed separately by the laboratory.

\_\_\_\_\_ (INITIAL)

### **PAYMENT AT TIME OF SERVICE**

If you do not have insurance or if your insurance plan is not in network, you will be expected to pay for services in full at the conclusion of your visit. \_\_\_\_\_ (INITIAL)

### **BALANCES AFTER YOUR INSURANCE**

You are responsible for any remaining balance (due to co-insurance, deductible or non-eligibility) that exists after your insurance has paid. If we know you have a remaining balance at the time of your appointment, you are expected to pay upon check-in that day, unless you have made prior arrangements or have been placed on an extended payment plan. After 90 days, all accounts with balances are turned over to a collection agency.

\_\_\_\_\_ (INITIAL)

### **NO SHOWS**

We ask that you contact the office no fewer than 24 hours prior to your scheduled appointment if you are unable to keep it. This allows us to accommodate others waiting for an appointment. There is a \$40 fee for missed appointments. Patients who fail to keep 3 scheduled appointments without adequate prior notice of cancellation may be discharged from the practice. \_\_\_\_\_ (INITIAL)

### **QUESTIONS REGARDING YOUR BILL**

If you have any questions on the bill you receive, please contact our billing company at 203-909-6868

*I certify that I have read and understand the "Financial Policy" and agree to all the terms and conditions as stated above.*

\_\_\_\_\_  
**PATIENT SIGNATURE**

\_\_\_\_\_  
**DATE**