Atlanta Center for Dermatologic Diseases Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

PAYMENT

Payment is expected at the time of your visit. We will accept cash, check, Visa, MasterCard and Discover. Payment will include any unmet deductible, co- insurance amount or non-covered charges from your insurance company.

- **Outstanding balances must be paid prior to any subsequent appointment** Please contact our billing office if you have questions or need to make a payment arrangement. All payment arrangements should be made before your next scheduled appointment.
- **Payment Plan Arrangement** We realize there may be circumstances that could make payment difficult. When these situations arise, we can assist you by arranging a payment plan. Our payment plan policy will allow monthly payments not to exceed 4 months with a minimum of $50.00 a month.
- **If you choose to be self-pay** while covered under an insurance plan, full payment will be required at the time of service. You will remain self-pay throughout the calendar year even with active insurance.

INSURANCE

IT IS YOUR RESPONSIBILITY to contact your insurance company and find out whether or not our doctors are participating within your particular insurance plan. It is also your responsibility to provide us with your correct insurance information. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. When insurance is involved we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier.

- **DEDUCTIBLE AND CO-INSURANCE: IT IS YOUR RESPONSIBILTY** to be aware of your insurance deductible. We want to make you aware that any procedures performed by us (wart treatment, injections, biopsies, etc.) will apply to a deductible. Office visits that do not require a co-pay may also apply to a deductible. We will only bill you the contracted rate that we have with your insurance company.
- **Preventative Care Services** Dermatology Medical Association does not have preventative care codes that can be filed.
- The Atlanta Center for Dermatologic Diseases, P.C. files claims to select insurance companies as a service to its patients. You are responsible for understanding your policy and any of its requirements pertaining to referrals, co-payments and deductibles.
- I authorize release of any information to my insurance company or the Social Security Administration or its intermediaries or carriers for the appropriate processing of medical claims.

RETURNED CHECKS

Returned checks will incur a $25.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $25.00 service charge.

COLLECTION AGENCY AND FEES

In addition to our monthly statements, we will attempt to notify you of your balance. After three attempts with no response, we will turn your account over to a collection agency. I understand that if my account is placed in collection status, I am responsible for any additional fees incurred. As a general rule, you are expected to pay all charges incurred before your next visit. A $25.00 service charge will be added should your account be turned over to an outside agency.

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CANCELLATION AND MISSED APPOINTMENT FEES

In order to provide all patients with the best care possible, we ask that you make every effort to keep your scheduled appointments.

If you need to reschedule or cancel an appointment, we require a minimum of 24 hours cancellation notice. Adequate notice allows us to offer the appointment to another patient who needs to see the physician. Please remember that confirmation reminders from us are only a courtesy. Our failure to confirm your visit does not relieve you of your responsibility to cancel your appointment.

A $50 fee will be charged when a patient fails to provide us with at least a 24 hour notice of cancellation, or missed appointment.

DIVORCED PARENTS OF PATIENTS

The adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible to communicate with each other about treatment and payment issues.

OUTSIDE LAB SERVICE All blood, pathological specimens, fungal and bacterial cultures will be sent to the lab for examination and analysis. You will be **BILLED SEPARATELY** for these services.

CONSENT TO MEDICAL CARE I hereby request and authorize the physicians, physician assistants and the professional staff, of the Atlanta Center for Dermatologic Disease's, to perform any medical or surgical procedures which in our professional judgment is deemed necessary to diagnose and/or treat the condition of concern, for the patient. I understand there are risks and benefits with receiving medical treatment. I understand medicine is not an exact science and there are no guarantees.

I acknowledge that I have read and understand the financial policy for the Atlanta Center for Dermatologic Diseases

Name _____ Date _____

Signature _____