ADVANCED
DERMATOLOGY + PLASTIC SURGERY

**SECTION I**

**OFFICE / FINANCIAL POLICY**

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE AND TREATMENT. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY, WHICH WE REQUIRE YOU TO READ AND SIGN PRIOR TO YOUR TREATMENT.

# PAYMENT IS DUE AT TIME OF SERVICE!

**WE ACCEPT CASH, CHECKS, VISA, MC, AMERICAN EXP, DISCOVER, AND CARE CREDIT.**

**Regarding Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.**

If you have insurance coverage with one of the plans we participate in, we will bill your insurance company in accordance with the guidelines of our contract. **However, we require that ALL CO-PAYS OR DEDUCTIBLES be paid at the time of service.** You understand that your **COPAY** is for an **OFFICE VISIT** and it may **NOT** apply to certain office procedures (such as excision, biopsy, cryotherapy, etc.) as dictated by your insurance policies. You are responsible for any amount not covered and /or applied to your deductible. No charges or payments are guaranteed until your insurance company processes your claims. Any amount remaining may be patient responsibility after your claim has been processed, even after you have paid in the office.

If we do not participate in your insurance plan, you are responsible for payment at the time services are rendered. You are responsible for obtaining reimbursement from your insurance.

**IF YOU HAVE MEDICAID, WE CANNOT SEE YOU**

**It is our office policy that since we are not a contracted provider with Medicaid we cannot see you. You will need to find a provider in the Medicaid network. Medicaid will not pay for any services since we are not a contracted provider. Medicaid may not cover any prescriptions that you receive from us.**

You will be required to show a copy of your insurance card and photo identification at the time of service for each visit. **If you do not have your insurance information you will be required to pay for the services rendered to you that day**. We do not accept third party insurance or auto accident claims.

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**Regarding Referrals: PRIOR TO THE VISIT, IT IS THE RESPONSIBILITY OF THE PATIENT TO OBTAIN A REFERRAL FROM THEIR PCP,** if required by the patient's insurance plan. We will **NOT** call the patient's PCP to solicit referrals!

**Minor Patients:** The parent (guardian) who presents the child for medical treatment is the responsible party. If payment for services is to be by someone else, the parent with the child should pay and have the other party reimburse them. Any legal agreement between the parents has nothing to do with this practice.

**Other Fees:** Your check will be accepted with proper identification and is subject to approval by Telecheck. There will be a $25 fee for each returned check.

**As of 01/01/2018**: **CANCELLATIONS OR MISSED APPOINTMENTS**. If you do not call and cancel your appointment at least 24 hours before, or if you No-Show, we will assess you a $25 missed appointment fee for office visits, $75 No-Show fee for Cosmetic appointments, and $100 No-Show fee for surgery visits.

**As Of 10/01/2018: DELINQUENT ACCOUNTS**. Accounts will be considered delinquent after 90 days. Delinquent accounts will be placed with a private collection agency. Any and all accounts placed with the collection agency will be subject to all reasonable collection and/or court costs. If you have any questions or concerns about your statements or accounts, please call the office at 281-351-9823.

Thank you for understanding our Office / Financial Policy. Please let us know if you have questions or concerns.

## SECTION II

## AUTHORIZATION AND ACKNOWLEDGEMENT

I have read, understand and agree to the above Financial Policy.

I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient Name: (Please print) _____ Date: _____

Patient /Guarantor Signature: _____