Advanced Derm-Plastic, P.A.
455 School St, Suite 49
Tomball, TX 77375
(281) 351-9823 FAX: (281) 351-7711

Patient Election: Self-Pay Status at Advanced Derm-Plastic

You have requested that you or your dependent's medical visits at Advanced Derm-Plastic, P.A. will be "self-pay" for services. By signing this form, you are acknowledging that you understand that Advanced Derm-Plastic will not bill any commercial insurance carrier or **Medicaid** for services provided, and that you are subject to the self-pay policies and guidelines as listed below.

Please be aware that:

- Self-pay services must be paid in full on the date of service (no payment plans provided).
- The flat rate for office visits does not include testing or procedures beyond your exam.
- You will be charged supplemental fees for any additional services including but not limited to biopsies, blood draws, or injections by these outside entities. The self-pay fee covers only the professional services provided by **Advanced Derm-Plastic, P.A**. You are financially responsible for all ancillary services including but not limited to laboratory or pathology testing, and will need to contact these external service providers directly for payment, pricing, or other queries.
- If more than three years passes between office visits, you or your dependent will be treated as a new patient upon your return. A higher initial office visit fee will be charged for this visit to reestablish you as a patient.
- If you have any commercial health insurance that you are electing not to bill for services, you will likely not be reimbursed by your carrier nor be able to apply these payments toward your deductible.
- **Advanced Derm-Plastic, P.A.** will not submit billing to your commercial insurance carrier for previously completed self-pay visits if you choose to revoke your self-pay status at a later date.

Medicaid

- We are not contracted with Medicaid. Medicaid will not pay our office as a non-participating provider and they will not cover any prescriptions that you receive if we see you. We ask you when making your appointment if you are covered by a Medicaid plan for this reason and since we are not contracted, **we will not bill them**.

Please select which of the below applies to you or your dependent:

☐ I do not have any commercial health insurance or my insurance company is not contracted with Advanced Derm-Plastic.

☐ I am covered by a contracted commercial insurance company, but I do not wish Advanced Derm-Plastic to submit a claim to my carrier. Instead, I elect to pay for all services out of pocket.

I freely choose to self-pay for medical services at Advanced Derm-Plastic and understand the associated clinic policies. I understand that if I wish to revoke this election and resume billing a contracted insurance carrier, I can do so by submitting the Advanced Derm-Plastic revocation form.

Patient Name: _____ DATE: _____

Patient/Guardian Signature: _____