Atlantic Dermatology Associates, P.C.
Dermatology and Dermatologic Surgery

Office Financial Policy

***Patient Name*: (Please print) _____**

Please read our policies so you will understand your responsibility regarding the charges for the services rendered to you by our office. We have made some changes that we would like you to be aware of.

We are a Medicare participating providers. We will file with Medicare and Medigap Carriers. If you do not have a Medigap, or if the insurance company with which we do not have a contract with, we will file a claim to your secondary/supplemental carrier. If no payment is received within 60 days from when we filed the claim, you will be sent a bill and responsible for the balance.

If we participate (in-network) with your commercial insurance plan under which you are covered, we will bill the carrier for services rendered. We will bill both your primary and secondary insurance plans. If we do not receive payment from your primary carrier within 60 days after we file the claim, you will be sent a bill and responsible for the balance.

You will be responsible at the time of service for payment of:

- Annual deductibles
- Copayments, and/or Co-insurance
- Charges for non-covered or Cosmetic Services

Payment is due within 10 days after receipt of the statement. Any balances not paid in full within six months from the first statement date, will be sent to an outside collection agency. Additional fees will be charged. If the account goes into intensive collections, a 30% of the balance will be added to the principal.

No Show Fee – If you do not give proper notice to cancel an appointment (24 hours), you will be charged a $50 fee for an office visit, $75 fee for patch testing, and $150 fee for scheduled surgery.

Self-Pay – If you are a self-pay patient, you will be required to pay $200 at check-in. You will receive a 20% discount of all charges incurred if paid in full at time of check-out. If charges are more than what was collected at check-in, you will be asked for the balance due at check-out. If charges are less, the difference will be returned to you at check-out. If you are unable to pay in full at check-out, you may ask for a payment arrangement with our Billing Department, however the 20% will not apply.

Form Fee – Form to be completed, you will be charged a form fee of $25.00. This must be paid prior to filling out the form.

Medical Records Fee – There may be a fee for requested medical records. Please check prior to requesting medical records.

Your signature below signifies that you understand our financial policy and your responsibility of charges on your account.

Patient Signature: _____ Date: ____/____/____

Parent/Guardian Signature: _____ Relationship: _____

Revised 5/1/21