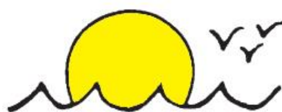

Atlantic Dermatology Associates, P.C.

Dermatology and Dermatologic Surgery

Office Financial Policy

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

Please read the following policies to help you better understand your responsibilities pertaining to our charges for the services we render to you as a patient of Atlantic Dermatology Associates, P.C.

We participate in Medicare and will consequently file your health insurance claim on your behalf with Medicare and Medigap carriers. If you do not have Medigap, or if you have a health insurance plan with which we do not participate, we will file your claim with your secondary/supplemental carrier. If we do not receive your payment within 60 days from the date in which we file your claim, you will be sent a bill and you will be responsible for any remaining balance.

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

At the time of service, you will be responsible for payment of:

- Annual deductibles, copayments, and/or co-insurance
- Charges for non-covered or cosmetic Services

Payment is due within 10 days after the date indicated on your statement. Any balances not paid in full within 3 months from your first statement date will be referred to an outside collection agency and you will be responsible for any and all costs of collection including, but not limited to, attorneys' fees.

No Show Fee – If you fail to provide us with proper notice of an appointment cancellation (at least 24 hours), you will be charged a $50 fee for an office visit, $75 fee for patch testing, and $150 fee for a scheduled surgery. Please note that you may be dismissed from our practice immediately and without notice for noncompliance if you accumulate 3 or more no shows.

Self-Pay – If you are a self-pay patient, you will be required to pay $200 at check-in. We currently offer a 20% discount on all charges incurred if paid in full at time of check-out. If your charges are more than what we collect at check-in, you will be asked to pay your remaining balance due at check-out. If your charges are less than what you paid at check-in, 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% discount will no longer apply.

Form Fee – You will be charged a $25 form fee which should be paid prior to our completion of your requested form.

Medical Records Fee – You may be charged a fee for requested medical records. Please inquire about this fee prior to requesting medical records.

Credit on Account – If you have a credit on your account of $25 or less, we will keep your credit on file. If your credit is over $25, we will refund t he applicable amount to you.

By signing in the space provided below, you acknowledge that you understand and agree to our financial policies as well as your responsibility of charges on your account.

Patient Signature: ____ Date: ____/____/____

Parent/Guardian Signature: _______________________________ Relationship: _________________