FINANCIAL POLICY FORM

Patient Name: _____ D.O.B.: _____ / _____ / _____

Thank you for choosing Alamo Heights Dermatology, PA as your healthcare provider. We appreciate your trust in us and the opportunity to provide you the best dermatological care. Please read, initial and sign the following financial policy. Please let us know if you have any questions.

Patient Payments

_____ The following payments are due at time of service (Copayments, coinsurance, deductibles, and any outstanding balance). We are contractually obligated to collect these payments due to the contract with your insurance company. Please send a form of payment with your child/children 18 and under if they are coming alone. We accept, cash, check, and all major credit cards. We can also keep a credit card on file for ease of payment.

Statements

_____ Statements will be sent on the 15th of each month to the address we have on file. If your address has changed, you are responsible for notifying us. Payment is due upon receipt of the statement. If you have any questions concerning your balance, please contact the billing department in our office as soon as possible. If your account remains unpaid, subsequent statements will be sent. We will send a total of three statements. If the account remains unpaid it will be forwarded to an outside collection agency for non-payment and an additional collection fee of 30% of the account balance will be added on the account.

Insurance Coverage

_____ Although we make every effort to verify your coverage, we cannot guarantee that the information given to us by your insurance carrier is correct. It is your responsibility to know what services may or may not be covered by your insurance. At the time of your appointment, we will charge you based on the most up-to-date information from your insurance plan. After insurance pays, there may be an additional amount due to us or a refund due to you. If your insurance carrier changes at any time, it is your responsible to update the office with your new insurance policy, along with a copy of the insurance card at your next appointment.

Pathology and Laboratory Services

_____ If a biopsy is performed, the pathology will be sent to an outside lab. The lab will send an invoice for their services. Since this is a third party, you will be responsible for payment to them directly.

Third party payers

_____ Our office does not bill third party payers, such as motor vehicle accident claims or worker's compensation claims. Should you wish to see one of our providers for one of these services, you will be considered self-pay and payment in full will be required at time of service. You will be supplied with a receipt and you may seek reimburse from them.

Adult Advocacy

_____ As an advocate for our patients, we will not intervene in any divorce dispute or financial responsibility dispute between married, legally separated, or other responsible parties. We will send statements to the address provided; however, we cannot look to more than one party for financial responsibility.

Cancelled or No-Show Appointments

_____ We require 24-hour notice for cancellation of scheduled appointments if you are more than 15 minutes late for your scheduled appointment, the physician will determine whether the appointment will need to be rescheduled. This courtesy will allow other patients to be seen in a timely manner. Missed appointments and appointment rescheduled less than 24 hours will be charged a $40.00 fee.

Fees

The following is a listing of fees charged

- Medical Records - $25.00 and up (based on pages of the chart)
- No Show or Less than 24hr cancellation $40.00; Aesthetician no show fee is $20. If you exceed 3 missed appointments within a 12-month period, the provider may choose to terminate you as a patient.
- Surgery No Show or less than 24hr cancellation $80.00
- FMLA – Disability Paperwork $25.00
- Returned Check Fee $30.00

I have reviewed the Financial Policy information and provide my consent regarding any and all the issues as stated in the policy above. I understand a copy of this policy will become a part of my medical records and I may receive a copy upon request.

_____

Signature of Patient/Legally Authorized Person/Financially Responsible Party (Must be 18 or over to sign)

_____

Date