Chart #_____

Patient Financial Policy

(Please read carefully)

Dermatology Consultants is committed to providing quality medical services at reasonable cost. To ensure effective communication and understanding between our patients and practice, we have adopted the following financial policy. If you have any questions concerning this policy, please discuss them with our billing department, as we are very sensitive to your individual financial constraints. If necessary, we encourage patients to contact our billing department to arrange an acceptable payment schedule.

For the following items, please indicate that you understand by printing your initials in the boxes:

Appointments:

☐ Patients who do not provide a minimum of a 24 hour notice to cancel an appointment will be considered a "no show". DCI reserves the right to discharge patients who accumulate more than 2 no shows within a 12-month period.

☐ I am aware that a $50 no show fee will be imposed for any missed appointments without 24-hour notice given.

Patients with insurance coverage:

☐ Patients ***with insurance coverage*** are ultimately responsible to understand the specifics of their individual insurance policy. The patient retains ultimate responsibility for financial charges. Please contact your insurance company at the phone number provided on the back of your insurance card for your policy details.

☐ We may provide services in our facility, such as blood work or pathology that is sent to outside sources. If your insurance requires specific providers of service to be used, or if you have any questions regarding the cost of service, please notify a staff member before services are rendered.

☐ We request payment of co-payments or out-of-pocket costs upon check-out. If this is not possible, please discuss with a staff member before services are rendered. If you are unable to make your payment upon your day of service, you may be asked to reschedule your appointment.

☐ Please have a current copy of your insurance card. If proof of insurance is not provided, you will be expected to make payment-in-full.

Patients without insurance coverage:

For the following items, please indicate that you understand by printing your initials:

☐ Patients ***without insurance coverage*** are ultimately responsible for financial charges. We request payment of services upon check-out of visit/procedure. Additional charges may apply after visit.

☐ If there are any questions or concerns related to cost of services, please ask to speak with a member of our billing department. If you are unable to make full payment at check-out, you may be asked to pay a standard minimum charge and the remainder of your bill within 30 days of the date of service.

We are disclosing this policy to you now to avoid a misunderstanding in the future.

I have read and understand this policy and my questions have been answered to my satisfaction.

Patient/Guardian Signature:_____ Date:_____