ANNAPOLIS DERMATOLOGY CENTER, PA

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Financial Policy

Please be advised that if you do not agree with any of the information described in this form, our office will be unable to submit insurance claims on your behalf and payment will be expected prior to services being provided.

Fees and Payments
Fees are standardized and are based on the complexity of your visit or procedure. Payment of copayments and any outstanding balance is required at the time of service. We accept Visa or MasterCard, personal and bank checks and gift certificates (with prior approval).

Making and Keeping Appointments
If you need to cancel your appointment please call at least 24 hours in advance. This allows us to accommodate other patients who need to be seen.

I understand that I will be responsible for a $25.00 fee for a regular office appointment and a $50.00 fee for any cosmetic or surgical excision appointment not kept nor cancelled within 24 hours of the scheduled appointment, this includes cancellations made the same day as the scheduled appointment. For non cash-paying patients, I further understand that I will need to reschedule my appointment if no referral or valid insurance information (card) is presented at the time of service.

Assignment of Insurance Benefits and Referral Requirements
I authorize assignment of my insurance benefits to be made on my behalf to Annapolis Dermatology Center for services furnished to me by their providers. I authorize release of medical information necessary to process insurance claims on my behalf. I understand that if applicable, I am required by my insurance carrier to obtain a written referral from my primary care physician prior to receiving professional services.

Non-Payment of Outstanding Accounts
Accounts that are not paid in a reasonable amount of time may be sent to an external collection agency or attorney for collection. Should my account be referred to a collection agency or attorney for past due amounts, I am responsible for all collections expenses including reasonable attorney's fees, not to exceed thirty-three percent (33%) of the outstanding principal/past due amounts.

Financial Responsibility
I also understand and agree with my insurance guidelines that regardless of my insurance status, I am ultimately responsible for the balance for any professional services provided to me. Payment is due at the time services are rendered which includes co-payments, unless other arrangements have been made in advance with the office's financial management. I understand that I am responsible for any deductible, coinsurance, or copay associated with my policy. I also understand that returned checks are subject to a $30.00 processing fee.

I have read all the information on this form and agree to the terms and arrangements noted on this form.

Signature of Patient _____ Date _____

Signature of parent, if Patient is a minor_____ Date _____