

## ARCADIA DERMATOLOGY FINANCIAL POLICY

(Effective January 1, 2006)

Thank you for choosing *Arcadia Dermatology* as your skin care specialist. We welcome you! We are committed to providing the finest in personalized and professional skin, hair, and nail care possible for our patients. Please carefully read and sign the following statement of our financial policy prior to treatment. Feel free to speak to our office personnel if you have any questions.

The patient or their guarantor is responsible for payment of services that are rendered. If we are a preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. Please present your insurance card at each visit. You will be responsible for all co-pays, coinsurances, and deductibles on the day of service. If a procedure is generally deemed to be "cosmetic" or elective in nature, we do not bill insurance companies directly. You must pay for the procedure in full and we will provide you with the necessary paperwork to submit to your insurance company upon request.

### ***IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS.***

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. If we do not receive payment within 60 days, the patient will be billed. If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. For your convenience, we accept VISA, MasterCard, American Express, Discover Card, cash, or check.

***All insurance information, including prior authorizations and referral forms must be provided at the time of service and before you are seen.***

Delinquent accounts will be subject to the following action. Accounts past due 90 days or more will be subject to reporting to the Collection Agency. All fees, including but not limited to collection fees, attorney fees, and court fees incurred shall become your responsibility in addition to the balance due this office. Interest is charged at 10% per month on the unpaid patient balance after 60 days (minimum \$5.00 re-bill fee.)

There will be a \$25 service fee for all returned checks. NSF checks must be redeemed with certified funds (cashier's check, money order, certified check, or cash.)

If you need to cancel a scheduled appointment, please contact our office at least **24 hours** before your appointment time. Because of high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent dermatological care. **A \$25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 24 HOUR ADVANCE NOTICE.**

**It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.**

I have read and I understand the above Financial Policy and I agree to abide by its terms.

\_\_\_\_\_  
PRINTED NAME OF PATIENT

\_\_\_\_\_  
SIGNATURE OF PATIENT/RESPONSIBLE PERSON

Date: