

# NORTHEAST DERMATOLOGY

## FINANCIAL POLICY

### RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review and request a copy of our Notice before signing this consent.

### PAYMENT OPTIONS

Payment is due at the time service is rendered. If you are covered by an insurance that we participate with, we will collect your office visit co-payment. We will file your claim with your insurance company after you provide us with complete insurance information. Insurance should not be considered a substitute for total payment. It is ultimately your responsibility to pay any deductible, coinsurance or any balance not paid by your insurance company due to non-covered benefits. If you do not have your copay at the time of service your account will be charged an additional \$15.00 fee billing fee. We accept cash, check, money order, Mastercard, Visa, American Express or Care Credit.

### REFERRALS

If your insurance company requires a referral from your primary care physician in order to authorize payment for the services of a specialist, you must obtain it prior to each visit. If this is not obtained, you will be responsible for payment of the medical bill at the time of service.

### NON- PARTICIPATING INSURANCE/NO INSURANCE/NO INSURANCE CARD

Patients who present to our office with non-participating insurance, no insurance or without their insurance card must pay in full at the time of service.

### COSMETIC PROCEDURES

It is your responsibility to make payment directly to us for any elective cosmetic procedure. Elective cosmetic procedures cannot be filed to insurance.

### RETURNED CHECK

We will charge a \$30.00 fee for all returned checks.

### COLLECTIONS

If your account must be turned over to collections, a 35% collection fee will be added to your account. However, rates are subject to vary.

### NO SHOW/ RESCHEDULE POLICY

We will charge a \$50.00 no show fee for all regular doctor appointments not canceled or rescheduled within 48 business hours of the appointment time. (Subject to change at anytime)

We will charge a \$75.00 no show fee for surgical procedures not cancelled or rescheduled within 48 business hours of the appointment time. (Subject to change at anytime)

Deposits for cosmetic procedures will not be refunded if the appointment is not cancelled or rescheduled within 72 business hours. (Deposits for cosmetic procedures may vary)

### AFTER HOURS NON EMERGENCY CALLS

If this call is not deemed a medical emergency by the physician on call, you will be charged a \$50.00 fee.

NORTHEAST DERMATOLOGY

***If you are aware of a financial situation that will delay payment of your account balance, please contact our Billing Department as soon as possible.***

**INSURANCE ASSIGNMENT AND ACKNOWLEDGEMENT**

I understand my insurance carrier can choose to assign benefits to Northeast Dermatology or my insurance carrier may make a payment directly to me. I understand and certify I am financially responsible for all health care service charges that are paid directly to me or by my insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charge for non-covered service provided to me or to any of my dependents. I am also responsible for providing up-to-date and accurate insurance information.

I authorize Northeast Dermatology to release to the Social Security Administration, Medicare and/or its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and any payment. I certify that I will pay to Northeast Dermatology any co-payments, coinsurance, deductibles or non-covered services. I will immediately pay to Northeast Dermatology any payments that I receive from my insurance carrier for series provided to me and/or my dependents. I

***By signing below, I am acknowledging that I have read and understand the above statements.***

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Legal Guardian Printed Name (if applicable)\*

\_\_\_\_\_  
Legal Guardian Signature

\_\_\_\_\_  
Date Signed