NORTHEAST DERMATOLOGY/SKIN DERMATOLOGY

FINANCIAL POLICY

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered the HIPAA Notice of Privacy Practices at Northeast Dermatology/Skin Dermatology which outlines my privacy rights and how Northeast Dermatology/Skin Dermatology may use and disclose Protected Health Information about me.

☐ **Yes** ☐ **No** ☐ **Offered but Declined** **Initials: _____**

PHOTOGRAPH FOR PATIENT IDENTIFICATION

I give my consent to the use of my photograph for identification on my electronic health record.

☐ **Accept** ☐ **Decline** **Initials: _____**

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 copayment. 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 $35.00 no show fee for all regular doctor appointments not cancelled or rescheduled within 24 hours of the appointment time.

We will charge a $50.00 no show fee for surgical and cosmetic procedures not cancelled or rescheduled within 48 hours of the appointment time.

AFTER HOURS NON EMERGENCY CALLS

If this call is not deemed a medical emergency by the physician on call, you will be charged a $30.00 fee.

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.

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INSURANCE ASSIGNMENT AND ACKNOWLEDGEMENT

I understand my insurance carrier can choose to assign benefits to Northeast Dermatology/Skin 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 any holder of medical or other information about me 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/Skin Dermatology any copayments, coinsurance, deductibles or non-covered services. I will immedicably pay to Northeast Dermatology/Skin Dermatology any payments that I receive from my insurance carrier for series provided to me and/or my dependents. I will also be responsible for any amounts not paid by my insurance for my failure to provide the appropriate insurance information for billing.

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

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