Dermatology and Skin Health of Dothan

Patient Responsibility and Financial Agreement

Name:_____ Date of Birth:_____

Please initial each paragraph below to indicate that you have read, understand, and agree with each of the terms listed below and will comply with fulfilling your financial and legal responsibility to pay for services received.

____ Health insurance policies are an arrangement between you, your employer, and your insurance company. We are NOT a party in that arrangement. Please be aware that not all services are a covered benefit by all health insurance plans and may differ by company. It is your responsibility to know if your plan covers both the office visit and any procedures provided by our practice. It is your responsibility to know if your insurance is active and in effect and if our providers participate in your plan (primary, secondary, or otherwise). Our staff will assist you in verifying that your coverage is active based on the information you have provided to us.

____ YOU are responsible for knowing if a referral is required by your insurance plan to see one of our providers (i.e. if you require a referral to see a specialist). The referral must be on file prior to your arrival or presented at time of check-in. Without the proper referral, your insurance plan will not pay for the medical services rendered and you will be considered self pay and payment will be expected at the time of service.

____ Upon check-in, we will collect any co-payments, prior balances, and payment for any non-covered services and/or your deductible as determined by insurance. Our practice is obligated by state and federal regulations to collect your insurance plan's assigned co-pay, deductible, and/or coinsurance. It is your responsibility to provide our practice with your current insurance card information along with your current residential address. We accept cash, checks, and most major credit cards. If balances are not paid within 90 days, a collection fee of $35 will be added to the account.

____ Outstanding balances will be collected before you are seen by one of our providers or a payment plan will be implemented. If you cannot pay at check-in, the appointment will need to be rescheduled.

____ There is a 3.0% fee to pay with a credit card. This is NOT our fee. This is the fee your credit card company charges for you to use the card. There is no fee for payments via check, cash, or debit card.

____ Laboratory and Pathology services are provided by a separate entity and a separate bill will be sent from their billing department.

____ The fees for no shows or cancellations with less than 24 hours notice are as follows: Office visit $50, surgical procedures $100.

____ Payment for cosmetic services is due on the day of service and a credit card on file will be required.

____ A credit card on file will also be required for payment plans, self pay patients, high deductible plans (>$500) and for future visits for patients who fail to pay their balance.

____ There is a $25 fee for any returned checks.

____ There is a minimum charge of $25 for completion of disability, FMLA, & cancer policy forms.

____ The fee for medical records is $6.50. There is no fee to access your medical records via the patient portal.

____ After 90 days, unpaid balances will be referred to a collection agency and you will be responsible for the payment of the balance plus the collection agency fee of 33.33% of the debt.

____ I understand that I am giving my consent to Dermatology and Skin Health of Dothan, PC to use and disclose my health care information to carry out treatment, payment activities, and healthcare operations of the practice. I authorize the release of any medical information to process insurance claims. I hereby authorize Dermatology and Skin Health of Dothan, PC to apply for benefits on my behalf for services and request that a payment from my insurance company be made directly to Dermatology and Skin Health of Dothan, PC.

_____ _____

Signature of patient or guardian Date