

Financial Policy

Thank you for selecting our practice for your dermatological needs. Our goal is to provide you with the highest quality of treatment and service. Your complete understanding of your financial responsibilities is an essential element of your care. If you have any questions about the following policy, please do not hesitate to ask our staff.

Billing & Insurance

Patients are responsible for payment at the time of service. We accept cash, check, MasterCard and Visa.

We are contracted providers with many insurance plans and will accept assignment of benefits. As a courtesy, we will file all claims, including secondary insurance, to the plans with which we participate. Please inform us of any special requirements in your plan.

You are responsible to pay for any co-payments, applicable dermatology procedures or cosmetic treatments at the time of each visit. Many dermatology procedures go toward your deductible. Please be aware that we collect an estimated payment on a few of these procedures at the time of check out (please refer to our Procedure Price List for details). Should your insurance pay these procedures in full, we will refund your payment upon receipt of your insurance payment. You are required to pay the deductible or co-insurance amounts designated by your insurance company. If your insurance company denies your bill, you will be billed directly for those services and are held financially responsible.

In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We encourage our patients to understand their policy and to contact their plan for clarification of benefits prior to services being rendered.

In addition, if you have coverage with an insurance plan that we do not contract with, we will prepare a receipt for you at the time of service with all the necessary information needed for you to file the claim. All charges for your care and treatment are due at the time of service for these health plans.

You must inform the office of all insurance charges, authorization referral requirements, and address changes. In the event the office is not informed before care is rendered, you will be responsible for any charges that are denied.

In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent.

You may receive a separate bill for laboratory or pathology services from an off-site lab for any tests your physician may order. Please discuss any billing errors or discrepancies with that laboratory.

In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In an event you are running late, please call our office. If you arrive more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.

Other Miscellaneous Fees	
Cancellation, Missed Appointments and Late Arrivals	If you need to cancel an appointment, we kindly request that you allow at least 24-hours notice so that your appointment may be given to another patient who may be in need of urgent care. If we do not receive 24-hours notice there may be a \$30.00 cancellation fee billed. Patients with multiple cancellations or missed appointments also may be discharged from our practice. In an event you are running late, please call our office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.
Returned Check Fee	There will be a \$25.00 charge for all returned checks.
Collection Fee	If your account is turned over to our collection agency, you will be responsible for the collection fee charged to us by the agency in addition to your outstanding balance

I have read and understand the financial policy, and I agree to be bound by its terms. I understand and agree that such terms may be amended in the future by the practice.

Signature of Patient or Responsible Party

Date

Printed Name of Patient

Date of Birth

For your convenience and as an option, we kindly request that you leave a credit card on file which may be used to reduce your remaining balance after insurance pays. Please complete and sign the following:

CREDIT CARD AUTHORIZATION

_____ I authorize North Dallas Dermatology Associates to bill my insurance for the
Initials services rendered today. Upon receipt of payment from my insurance company,
I authorize North Dallas Dermatology Associates to charge the below listed
credit card in the amount of the remaining unpaid balance.

_____ I understand that cosmetic procedures are not billed to my insurance. Should
Initials there be a remaining balance on cosmetic services, I authorize North Dallas
Dermatology Associates to charge the below listed credit card in the amount
of the remaining unpaid balance.

_____ An email will be sent to notify me of the additional charge to my credit card.
Initials

Name as it appears on credit card

Last four numbers on credit card

Credit card expiration date

Credit Card Billing Address:

Address line 1

Address line 2

City, state, zip code

Email address

Credit card holder authorizing signature

Date