

ADVANCED DERMATOLOGY AND LASER CENTER

Patient Payment Policy

Thank you for choosing our medical practice. We are committed to providing the best possible medical care. The following information is provided to avoid any confusions regarding payment for professional medical services. Please sign below that you have read and agree to this Policy.

PLEASE PRESENT INSURANCE CARD AT THE TIME OF VISIT

Payment Policy

Payment for service is due in full at the time of service.

- We accept cash, check, Visa, Master-card, Discover and American Express.
- You are responsible to pay your co-pay/co-insurance and/or deductible at the time of visit.
- All fees are based on the type of service provided for your care and related services.
- If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account in accordance with the policies outlined above.
- For Cosmetic or uncovered surgical services, payments are due at time of service.
- If your account is overdue longer than 90 days, it will be referred to a collection agency. A \$25 collection fee will be added to your account. This is a last resort, done reluctantly and after we have exhausted efforts for voluntary payment.

Laboratory/Pathology Services

We rely on the services of Quest and Spectrum Laboratories for blood-work and Dr. Lawrence Klein, Columbia Dermatology Lab for tissue biopsy interpretations. You will receive separate billings from their offices. If you have any questions regarding a bill from them, please contact them directly.

Insurance

As a courtesy, we file insurance. It is your responsibility to notify this office of any changes to your Insurance Coverage. Your insurance policy is a contract between you and your insurance company. We are not party to this contract. In the event we do file insurance and your insurer has not paid within 30 days from filing, you will be billed for the entire amount. It is your responsibility to contact your insurance company if payment has not been made.

Acknowledgement and Authorization

I have read, understand and agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Advanced Dermatology and Laser Center.

I authorize Advanced Dermatology and Laser Center to release any medical or other information to my insurance company when requested.

Signature

Date

Printed Name