
PATIENT NAME

MEDICAL RECORD # (office use)

AFFILIATED DERMATOLOGISTS, S.C.

POLICY REGARDING PATIENT FINANCIAL RESPONSIBILITY

Providing quality medical care for our patients is our primary concern. The following is a summary of our financial policy. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided here. This authorization is valid until notified otherwise.

We accept certain insurance plans; therefore, please **provide us with your insurance card**. If you wish to be seen, you are responsible for payment of all **co-pays at the time of service**. If your insurance is a plan for which we are not a designated provider, we are more than willing to provide care and you will be responsible for payment at the time of service.

Please remember that insurance policies **may not cover all conditions and fees**. To be fully aware of your schedule of benefits, please **read your insurance policy or talk with your insurance representative**.

Some procedures performed are considered cosmetic and will not be covered by insurance. Any laboratory analysis that we require, but do not perform in-house will be sent to an external laboratory. **You may receive a separate bill for laboratory services**.

We accept Medicare and will file all claims for patients with Medicare. Please give us your secondary insurance card and we will also file it.

We accept payment in the form of cash, check, VISA and MasterCard.

You will be charged \$25.00 for each check returned for insufficient funds.

DISCLOSURE

I understand and agree that services have been rendered **for which I am fully responsible**, whether or not medical or other insurance should cover the cost of at least a portion of the services rendered, and I further understand and agree that in the event that I default on any payments due and owing Affiliated Dermatologists, S.C., for such services, **I will pay any and all costs of collection** of such payments due and owing, including, without limitation, reasonable attorney's fees, 3rd party collection agency fees, court costs, and any other such costs.

Agreed to as of the date signed below.

Signature of Patient or Legal Representative

/

Date

Printed name of Legal Representative, if other than Patient

/

Relationship to Patient

Practice Witness

