

**PATIENT FINANCIAL POLICY**

Thank you for choosing our practice. We are dedicated to providing the best possible care and services for you and regard your understanding of your financial responsibilities as an essential element of your care. Please read the following carefully and sign at the bottom to confirm your understanding.

- 1) **Insurance:** your visit is filed with carriers for whom our practice has a valid contract. It is the responsibility of the patient to provide accurate insurance and personal information including any preferred laboratory cards. If your insurance requires a referral, it is your responsibility to provide the referral prior to your visit. You will be responsible at the time of service for the payment of: **Co-Payments, Unpaid Deductibles, and Past Due Balances.**
- 2) **Self-Pay and Cosmetic: Payment is expected in full at the time of service.**
- 3) **Pathology:** is ordered by physicians to properly diagnose certain skin disorders. To increase the quality of care for our patients, we utilize a licensed lab within our medical practice. The analysis of these specimens is then performed by an independent board-certified Dermatopathologist who specializes in the microscopic diagnosis of skin disorders. Charges for these services are in addition to your office visit charge and procedure charge.
- 4) **Cancellation and Missed Appointments**
  - a) Office Visit –I understand that it is my responsibility to cancel my appointment 24 business hours in advance of my appointment time and date.
    - **Fee is \$50.00 and is not covered by your insurance plan.**
  - b) Surgical Appointments –I understand it is my responsibility to cancel or change my appointment 5 business days prior to my appointment time and date.
    - **Fee is \$250.00 and is not covered by your insurance plan.**
  - c) Cosmetic Procedures
    - All procedures, which are time intensive and cost \$500 or more, will require a 50% deposit to schedule an appointment. Patients who No Show or Cancel without giving a 5 business day notice will lose their deposit.
- 1) **Requests for Medical Records and Completion of Forms (such as Cancer Policy, Disability, etc):** Fee for medical records is \$20 plus the cost for mailing and/or electronic device. Completion of forms is subject to a fee of \$25. Upon receipt of payment, documentation will be returned or can be picked up within 3-5 business days, unless otherwise notified.
- 2) **Methods of payment accepted are**
  - i. Cash, Visa, MasterCard, American Express, Discover
  - ii. Personal checks with proper identification (valid Driver's License or photo ID). A \$30.00 overdraft charge will be added to the insufficient funds amount of any returned checks
- 3) **Delinquent Accounts: If your bill is unpaid or your insurance does not pay appropriately within a month of the service, you will be responsible for payment in full. A collection agency may be chosen to manage delinquent accounts. If your account is placed with a collection agency, you will be responsible for all costs of the collection services as well.**

**I have read the financial policies of ASLC and understand my financial responsibilities as a patient. I understand that failure to make payment when due is the basis for legal action, and agree to pay all costs of collection, including court cost and attorney fees. The signature below confirms agreement to the above as a patient or the responsible party for the patient.**

**PATIENT/GUARANTOR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**