FINANCIAL POLICY

SKIN reserves the right to change this policy without notice.

We are committed to providing you with outstanding dermatologic care. Currently, we file claims for Medicare, CareFirst Blue Cross Blue Shield PPO, Cigna PPO, United Health Care and Aetna. However, the deductible and co-pay might be required at the time of the office visit. After the claim has been filed and processed, there may be an unpaid balance which is the patient's responsibility. Patients with insurance coverage not listed are responsible for paying for medical services directly. You may then be reimbursed by your insurance company, under the terms of your arrangement with them.

AUTHORATIZATION FOR ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I authorize Skin, PLLC to apply for benefits from my insurance carrier and further authorize payment directly to Skin, PLLC for the medical benefits, if any, otherwise payable to me for services rendered by Skin, PLLC. I understand that this service is available for health plans the Skin, PLLC participates and will only be submitted for the primary insurance plan unless my primary insurance plan is Medicare. I further authorize medical information required by my health insurance carrier or its designated review agent, required for payment, or (if applicable) my employer's worker's compensation insurance carrier in order to determine benefits to which I may be entitled, or to designated agents of Skin, PLLC. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or by my insurance carrier at any time in writing. **I hereby assume financial responsibility for and agree to make payment in full to Skin, PLLC for all charges for services provided not otherwise authorized or paid by my insurance carrier.** Payment is to be made within fourteen (14) days as statements are presented with settlement in full, or payment arrangements to be made with Skin, PLLC. I certify that the information given is true, accurate, and complete to the best of my knowledge, and further authorize Skin, PLLC to investigate any and all information given concerning this or related claims. **Any outstanding balances after 60 days may be referred to an outside collection agency. Accounts referred for collection may be subject to an additional collection fee of 35% as well as any legal fees, which will be added at the time the account is reported for collection. Patients with delinquent accounts or accounts in collections may be discharged from the practice.**

PATIENT AGREEMENT

I understand that I am financially responsible for all charges incurred. As per above, payment is due at time of service. We accept **cash, Visa, Mastercard, Discover and AMEX**. We **DO NOT** accept personal checks. **If I am unable to keep my scheduled appointment, I agree to give 24 hours notice; otherwise, I may be charged a fee, depending on the length of the schedules appointment.**

Signature: ____ **Date:**______________