

## DERMATOLOGY AFFILIATES, PC

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Thank you for choosing our practice. Our goal is to provide excellent care and superior patient service. Our policies are intended to accomplish that goal in a cost-effective manner. Your agreement to follow these policies will help us serve you well.

### Payment

- For your convenience we accept cash, personal checks, debit cards, Visa, MasterCard, American Express, and Discover. Co-payments and outstanding account balances are due at the time of service. Once insurance has processed a claim, bills are sent for outstanding balances; these are due upon receipt. We are not able to offer payment plans. For your convenience, we can keep credit card information on file in a protected location to pay balances.

If you do not have insurance, or it cannot be verified, total payment for your visit is due at the time of service.

### Insurance

- Your correct insurance card(s) must be presented at each visit to assure that claims are sent to the correct company and no one is using your insurance fraudulently. For the same reason, we must have a government issued photo ID on file.
- We will file claims to your insurance carrier and accept payment directly from them. We must have your complete and current demographic and insurance information to do this. It is your responsibility to let us know about any changes in your insurance coverage and contact information. If we submit with the information you have on file with us and the claim is denied due to incorrect or missing information, we will bill you for the full amount and you may file for reimbursement from your insurance company.
- It is your responsibility to know that the physician you are seeing participates in your plan. If you make an appointment with a physician that is not currently in your plan, you may be responsible for the charges.
- Since insurance benefits are unique to each patient's insurance coverage, it is your responsibility to know your insurance benefits PRIOR to services being rendered. We are not responsible for unpaid amounts as a result of deductibles or denials from your insurance company. **We can never guarantee insurance coverage for any service provided.** You are responsible for charges denied by your insurance company as not medically necessary.
- Generally, insurance plans classify dermatology procedures as surgery. Many insurance plans apply procedures to a deductible, so some or all charges may be your responsibility.**
- If your plan requires a referral or prior authorization, it is your responsibility to obtain this prior to your visit.

### Labs

- Most laboratory tests ordered through our office are billed separately to your insurance by either LabCorp, Finan Templeton, DermPath, or Quest Diagnostics. If you receive a bill from one of these companies, please contact them to resolve any questions.
- If your insurance requires that tests be sent to a specific lab, it is your responsibility to tell the nurse at the time the test is ordered. We will not pay for any lab charges.

### Cosmetic and Elective Services

- Full payment is required at the time of service. Cosmetic and elective procedures may require a deposit or payment in full to hold the appointment. Please be aware that a missed appointment can result in loss of some or all of your deposit.

### Patients Under 18 Years Old

- The patient registration form must be signed and guaranteed by the parent or legal guardian accompanying the minor at the first appointment. That guarantor is legally responsible for payment.
- We are unable to know the financial responsibilities of divorced parents. The adult accompanying the minor is responsible for payment of the patient portion due at the time of service.
- When a minor becomes 18, s/he will sign this form and may designate parental rights for information and payments.

### Fees

- Returned check fee: A \$25 fee will be due for any check returned from the bank for non-payment.

**I have read the financial policy and I understand and agree to this policy. I understand that I am financially responsible for all charges whether or not covered by insurance. I have been offered a copy of this policy.**

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of patient or responsible party

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Printed Name of Responsible Party if not Patient