THE DERMATOLOGY CENTER OF INDIANA

1100 Southfield Drive, Suite 1240
Plainfield, IN 46168

6639 Whitestown Pkwy
Zionsville, IN 46077

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Please return this form at your appointment

Patient Information:

In order to avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of the office. **This document must be read and signed by each patient** and will remain in effect for all services rendered during your time as a patient in our practice. We are committed to giving each patient the best dermatologic care possible.

Insurance Claims:

Your insurance policy is a contract between you and your insurance company.

At the time of your first visit our staff will contact your insurance company for verification of coverage, **co-pay** and **deductibles**. **Payment will be collected at time of service.** We will file for our services with your primary insurance company. Secondary insurance will be filed if adequate information is provided at the time of service.

Method of Payment:

For your convenience, The Dermatology Center of Indiana, PC accepts **Cash, Check, Visa, MasterCard and Care Credit.** There will be an additional charge for any returned checks.

Accounts Past Due:

Should any bills go unpaid and a collection agency referral becomes necessary there will be a 20% processing fee assessed on the principle balance. All fees assessed by the collection agency (collection fees, court costs, attorney fees, interest etc.) will be the responsibility of the patient or guarantor.

Minor/Dependent Patients:

The adult accompanying a minor/dependent, or the parent(s) or guardian(s), of the minor or dependent is responsible for full payment. For unaccompanied minors, non-emergency treatment may be denied unless payment is collected at the time services are rendered. Children under the age of 18 will require the signature of a responsible adult party on the registration form.

Your signature below indicates that you accept and understand this policy. Further, your signature authorizes The Dermatology Center of Indiana, PC to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to The Dermatology Center of Indiana, PC, when an assigned claim is filed.

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Signature of Patient or Legal Guardian Date