THE DERMATOLOGY CENTER OF INDIANA

# PATIENT FINANCIAL RESPONSIBILITY STATEMENT

The Dermatology Center of Indiana is committed to serving our patients with professionalism and provide the best dermatologic care. We expect the same commitment from our patients. This includes being on time for your appointment and calling to cancel your appointment if you are unable to make it. It also includes financial responsibility, such as presenting your current insurance cards at each appointment and paying the patient responsibility portion of your visit with cash, check, Visa, Mastercard, Discover or CareCredit. It is your responsibility to provide complete and accurate insurance information including referral documents from other providers if needed.

## Referrals/Authorizations

It is your responsibility to obtain a referral or authorization from your primary care physician if required. If we do not have one on file the day of your appointment, you will be expected to pay for the services rendered or reschedule your appointment.

## 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 expected 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.

## 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. All future appointments will be cancelled until account is paid in full.

## Return check fees

There will be a $30 fee for all returned checks

## Missed appointment or appointments not cancelled within a 24 hour notice

There will be a fee of $30 for any missed office visits and $50 for any missed office procedures.

## Untimely insurance information provided from patient

If you fail to provide the most current insurance information to our office in a timely manner and it goes past the insurance companies timely filing guidelines, you will be responsible for any charges incurred at your appointment.

## 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