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Coastal Dermatology and cosmetic center

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Financial Policy and Patient Responsibilities

Thank you for choosing Coastal Dermatology & Cosmetic Center, Inc. as your medical provider. The following is a statement of our Financial Policy which we require you to read and sign prior to receiving any services.

Check-In

Your first visit to a dermatologist is important, and it will be much easier for you and our office if you are well prepared.
Arriving 5-10 minutes early with your completed paperwork will expedite the check-in process. Please bring your current insurance card(s) with you to each visit as well as a form of photo identification. Without the insurance card(s), we will be unable to file your insurance claim and you will be responsible for all charges for that visit.
On follow-up visits, you will be asked to verify all demographics and insurance information so that our records remain current. We understand your time is valuable and will do everything possible to keep you from waiting.

Insurance

Our practice participates with most health insurance plans. Every insurance plan is different. We strongly recommend that you check with your insurance carrier regarding your plan's benefits and coverage, and it is the ***patient's responsibility*** to understand his/her medical benefits.
Routine in-office procedures include but are not limited to biopsies, injections, destruction or surgical procedures. These are billed separately from your office visit and may or may not be covered by your insurance or applied toward your deductible. Pathology services will be billed separately from an outside facility. We will gladly file your insurance claim on your behalf. We allow 60 days from the date the claim is filed for the insurance company to pay. If the insurance company does not pay within this time, you will be responsible for the balance.

Referral

If your insurance requires a referral, please have your primary care physician to send the referral to us prior to your appointment. Failure to obtain a referral may result in rescheduling your appointment or you may choose to be seen without the insurance benefits and pay for your visit in full.

Co-Pays

All office ***co-pays*** are to be paid at the time of service. ***This is an insurance company policy.*** For your convenience, we take cash, check and all major credit cards. Any returned check from the bank for non-payment shall result in the patient's or Guarantor's account being assessed a $25.00 fee per check.

Deductibles & Co-Insurance vary among insurance plans. Health insurance deductibles/co-insurances require the insured to pay a certain amount out-of-pocket toward his/her health coverage before the insurance company has to begin paying under the policy. Please check with your insurance company to determine the amount of your plan deductible.

No Insurance or Self-Pay

Payment will be due at the time of service. If you are unable to pay your balance in full, we will gladly arrange a payment plan. Arrangements must be made with our Billing Department prior to your appointment.

The following fees will not be filed with your insurance carrier; they are the direct responsibility of the patient:
No-Show

Any patient that does not show for their scheduled appointment and does not call to cancel their scheduled appointment at least 24 hours in advance. We will charge a $25 "no show" fee for routine office visits and a $50 "no show" fee for surgical and procedural appointment. Payment is due upon receipt of statement.

I have read, understand, and agree to the financial policies as outlined.

I acknowledge full financial responsibility for services rendered by Coastal Dermatology & Cosmetic Center; I understand that I am responsible for prompt payment of any portion of the charges including co-pays, deductibles and coinsurance amounts. I understand that payment of co-pays, deductibles and co-insurance amounts is expected at the time of visit. I agree to be responsible for all reasonable attorney fees and collection costs in the event of default of payment of my charges.

Print Patient Name: _____ Date_____

Signature of Patient or Responsible Party: _____

Legal Representative's Relationship to Patient: _____