

## FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office.

- Payment is required in full for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payment and deductibles will be collected.
- Any unpaid balance, after insurance payment, is due from the patient. Since our relationship is with the patient, the bill is the patient's responsibility. The patient will receive a monthly statement any time there is a balance on the patient's account that is considered patient responsibility. **If the entire balance cannot be paid in full, our business office can arrange a payment plan for the patient.**
- Co-pays are due at the time of treatment. These amounts vary depending upon which managed health care plan the patient may have.
- Payment may be made by cash, check, VISA, MasterCard, Discover, or American Express.
- There is a \$25.00 charge to the patient for returned checks due to insufficient funds or closed accounts.
- We accept Medicare assignment and participate in a number of HMO's, PPO's and other managed care plans. We must have a copy of the patient's insurance card and all insured party information including date of birth and Social Security Number to process the claim.
- Financing options are available through [\*\*CareCredit\*\*](#). Please inquire at checkout.

## MEDICAL RECORDS

Patient fee for copying of records is \$.50 per page for the first 25 pages, and \$.25 **per page** thereafter.

Please review your Explanation of Benefits from your insurance carrier. If you have any questions or feel you are due a refund from The Dermatology Clinic, please contact our billing office at (501) 623-3400. We are always willing to be of assistance to you.

Your signature below signifies your understanding and willingness to comply with this policy.

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*Patient Signature*

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*Date*