THE DERMATOLOGY CLINIC OF SOUTH FLORIDA, PA

Financial Policy

The following is a statement of our financial policy which we require you to read and sign. For your convenience, we accept checks and Master Card or Visa.

Insurance

We cannot file your insurance unless all of your insurance information is given at the time of your visit. It is therefore necessary for us to have a current copy of your insurance card for accurate billing. Insurance benefits will be verified by our office, but it is recommended that you educate yourself about your individual benefits by contacting your insurance company before being seen. It is required that we hold you responsible for your portion of the charges, including copayments and deductibles, at the time of service. If your insurance company has not paid a claim within 60 days, you may receive notification in the mail requesting your assistance in determining if there is a problem or if additional information is required in processing the claim. The patient is ultimately responsible for all professional fees.

Non-Covered Services

There are a number of services we provide that are typically considered "cosmetic" by your insurance company. For example, removal of some normal growths such as skin tags are not routinely covered by health insurance plans. Other services considered not medically necessary are Botox, fillers, chemical peels, and sclerotherapy. Full payment for all non-covered services must be made at the time of your visit.

Referrals

In the state of Florida, referrals are not usually required. If your insurance company does require a referral, it is solely your responsibility to obtain a current referral for office visits. You must bring the referral to our office on the day of your appointment.

Labs

If you are aware that your insurance carrier requires you to utilize certain labs for blood work or biopsies, you must inform the office. A copy of your insurance card with the specimen will be sent to an outside facility. These charges are billed directly from the lab itself and are separate from our office charges.

Self Pay

If there is any concern regarding the charges for today's visit, please ask for an estimate. It is recommended that you ask prior to the visit rather than after services are rendered.

Payment is due at the time of services rendered unless prior arrangements have been made with the office.

Thank you for your understanding of our policies. Please let us know if you have any questions or concerns.

I have read the above financial policy, and I understand and agree to its terms.

_____ _____

Signature of Patient/Guardian Date

Authorization of Payment and Release of Information

I request payment of authorized insurance benefits be paid to THE DERMATOLOGY CLINIC OF SOUTH FLORIDA, PA and authorize release of medical information to determine payable benefits for services rendered.

_____ _____

Signature of Patient/Guardian Date