George Dermatology

MARY NOËL GEORGE, MD, FAAD

Thank you for choosing George Dermatology. We are dedicated to providing the best possible care and services for you. Knowing your financial responsibility is an essential element of your care. With healthcare costs shifting more to patient responsibility, it is essential that you understand your deductible and details of your plan. **Please read the following carefully and sign at the bottom to confirm your understanding.**

1) Insurance: Your visit is filed with the carrier with whom our practice has a valid contract. It is the responsibility of the patient to provide accurate insurance and personal information. If your insurance requires a referral, it is your responsibility to provide the referral ***prior to*** your visit. You will be responsible at the time of service for the payment of copays, unpaid deductibles, and past due balances.

2) Self-pay and cosmetic: Payment is expected in full at the time of services.

3) On occasion, pathology is ordered by physicians to properly diagnose certain skin disorders. To provide quality care for our patients, we utilize an independent licensed lab with analysis performed by a board-certified Dermatopathologist who specializes in the microscopic diagnoses of skin disorders. *Charges for these services are **in addition** to your office visit charge and procedure charge.*

4) Cancellation and Missed Appointments: We understand that unexpected events, illnesses, etc occur. When this happens, call our office as soon possible to inform us of such issues. In the case of missed appointments or cancellations within 24 hours of the appointment:

- Office Visit - I understand that it is my responsibility to cancel my appointment at least 24 hours in advance of my appointment time and date; otherwise, a $50 fee will be billed to my account which is not covered by my insurance plan. All outstanding balances must be paid in full before your next visit.
- Surgical appointments - I understand it is my responsibility to cancel or change my appointment at least 24 hours in advance of appointment time and date; otherwise, a $200 fee will be billed to my account which is not covered by my insurance plan. All outstanding balances must be paid in full before your next visit.

5) Requests for Medical Records/ Forms (FMLA): Fee for medical records is $25 plus the cost of mailing and/or electronic device. FMLA, medical and other such policy forms to be filled out will be charged $10 fee.

6) Methods of payment accepted are: Cash, Visa, Mastercard, Discover, and personal checks with proper identification (valid Driver's license or photo ID). A $30.00 overdraft charge will be added to the insufficient funds amount of any returned checks.

7) I have read the above financial policies and understand my financial responsibilities as a patient. I understand that failure to make payment when due is the basis for legal action and agree to pay all costs of collection, including court costs and attorney fees.

8) Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. *Many policies have large deductibles and/or copayments that won't be known until after your services are submitted to your insurance carrier. Even if a procedure is covered by insurance, you may still receive a bill.* These external factors make it necessary for George Dermatology to maintain a credit card on file for all patients. The card information is stored in a confidential, secure merchant account. Once your insurance company notifies us how much of the bill is your responsibility, we will mail one statement to obtain payment. After 30 days, we will charge your credit/debit card and provide you with the confirmation of the charge. If the balance is over $200, you will receive one courtesy call from our billing office regarding the payment a few days prior to charging the card. By signing this form you authorize George Dermatology to bill your card on file that are determined to be the patient's responsibility by the insurance company.

Name as it appears on credit card _____Cardholder Signature_____

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Patient (Guardian) Signature / Name of patient Date

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