

**DERMATOLOGY ASSOCIATES, PSC
2811 KLEMPNER WAY
LOUISVILLE, KY. 40205
(502) 896-6355**

FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE FOR ALL PATIENTS WITHOUT INSURANCE COVERAGE OR PROOF OF INSURANCE COVERAGE. PRIOR TO SEEING THE PHYSICIAN YOU WILL NEED TO MAKE A PREPAYMENT; ANY REMAINING BALANCE WILL THEN BE PAID AS YOU LEAVE THE OFFICE. IF YOU HAVE BEEN SEEN IN OUR OFFICE WITHIN THE LAST 3 YEARS YOUR PREPAYMENT AMOUNT WILL BE \$60.00, IF YOU ARE A NEW PATIENT OR HAVE NOT BEEN SEEN WITHIN THE LAST 3 YEARS YOUR PREPAYMENT AMOUNT WILL BE \$85.00. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DISCOVER.

We accept assignment of benefits on many insurance plans. If we accept assignment for your plan you will be responsible to pay any **copay** amounts **each visit**. You will be responsible for any deductible/coinsurance as stated in your policy. Any charges considered cosmetic or not medically necessary will be your responsibility and will be **due in full at time of service**.

If we do not participate with your plan, you may be responsible for a higher amount out of pocket. You will pay your copay, if any, and deductibles/coinsurance as stated in your plan. We will bill your insurance, however, if they do not respond within 45 days the balance will be automatically transferred to your responsibility. **We charge usual and customary rates for our area and you would be responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

Adult patients accept full responsibility for payment of any copays, deductibles, or coinsurance on their own account. Minor patients **must** be accompanied by a parent or legal guardian **each visit**. The parent/legal guardian accompanying the minor to the first visit will be assigned as guarantor on the account, accepting full responsibility for payment of copays, deductibles or coinsurance on the minor's account.

We strive to provide our patients with as much information about their financial responsibility as possible. There are occasions when an insurance company considers certain procedures to be non-medically necessary or cosmetic. If we know a procedure will not be covered we will notify the patient prior to rendering services. Dermatology Associates, PSC cannot guarantee coverage for any of the services we provide. Any services denied by your insurance company as non-medically necessary or cosmetic will ultimately be the patient's responsibility to pay.

All balances deemed to be the responsibility of the patient are to be paid in full within 30 days of receipt of your first invoice. If you are unable to pay in full our billing department staff is happy to discuss payment arrangements. Any balance that goes unpaid for more than 30 days will be charged 1.5% interest (minimum \$2.00) monthly on total balance due. Any balance that goes unpaid for more than 90 days is subject to being transferred to an outside collection agency.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I HAVE READ THE FINANCIAL POLICY AND I UNDERSTAND AND AGREE TO THIS POLICY.

X _____ DATE _____
Signature of Patient or Responsible Party