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 annually. For your convenience all payments can be accepted via cash, personal checks, Visa, MasterCard, or Discover.

Self-pay / Un-insured patients: Full payment is due at the time of service for all patients without insurance coverage or proof of coverage at the time of their visit. Prior to seeing the physician you will need to prepay a portion of your charges; any remaining balance will then be collected as you leave the office. If you have been seen by one of our physicians within the last 3 years your deposit amount will be $96.00. If you are a new patient or have not been seen within the last 3 years your deposit amount will be $142.00.

For non-contracted insurance plans: We accept assignment of benefits on many insurance plans; however we do not participate with your particular plan. As a result 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 will be responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.**

For contracted insurance plans: We accept assignment with your insurance plan you will be responsible to pay your copay amounts **each visit** per your insurance carrier's guidelines**.** You will also be responsible for any deductible and/or coinsurance amounts 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 your plan has a deductible which has not been met you will be responsible to pay a deposit of $50.00 prior to your visit.**

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.

*****The removal of skin tags is considered cosmetic, non-covered, or not medically necessary and therefore will not be billed to your insurance carrier for consideration. Patients electing to have this service performed understand that they will be personally and fully responsible for payment of this procedure at the time of their visit. The charge for this service is $125 for the first 15 tags and $75 for each additional 10 tags that are removed.*****

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 may 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