



A Children's HOUSE For Pediatric Dermatology

A CHILDREN'S HOUSE FOR PEDIATRIC DERMATOLOGY FINANCIAL POLICY and ACCEPTANCE OF LIABILITY

Thank you for choosing A Children's House for Pediatric Dermatology as your health care provider. It is our goal to meet patient needs and address any patient concerns effectively. In an effort to keep patients informed about our policies so they can make educated decisions regarding their health care, we ask that all patients read and sign a copy of our Financial Policy prior to receiving services and treatment.

PAYMENTS are expected at the time services are rendered. This includes payment of all fees including fees for the office visit and any procedures performed in the office. If you are unable to pay at the time of service, your appointment may be rescheduled.

INSURANCE is not accepted in our office as we are not contracted with any insurance companies. Therefore, we do not file claims with your insurance. We will provide you with an itemized receipt upon payment that you can independently submit to your insurance carrier for possible out-of-network reimbursement.

OUTSIDE SERVICES may be necessary for your medical care. **PATHOLOGY** is ordered by our physician when a skin biopsy is performed. We utilize a licensed dermatopathology lab that specializes in the microscopic diagnosis of skin disorders. Pathology charges will come directly from the lab. **LABORATORY TESTING** fees for bloodwork and microbial cultures will also billed directly from the lab. As well, **HOSPITAL** fees for outpatient surgical procedures will be authorized and billed from those entities. All of these fees may or may not be covered by your insurance. We will specifically discuss this with you if it is determined that these services are recommended for appropriate diagnosis or treatment in your care.

RETURNED CHECKS will result in a \$50.00 service charge. The check amount plus the service charge is to be paid within 10 days of notification. Failure to pay in full in 10 days will result in collection through the appropriate means.

WALK OUT POLICY: Payment for services is expected on the day of service. Any patient who walks out without making or arranging payment will be assessed a \$50.00 walk out fee.

NO SHOW/LATE CANCELLATION POLICY: As a courtesy, we make every effort to confirm appointments in advance; however, it remains your responsibility to know and to keep your appointment. If you are unable to attend an appointment, please let us know as soon as possible so we can assign your time slot to someone else. We ask for at least one business day cancellation notice for all appointments. We reserve the right to charge the following fees for missed appointments: \$50.00 for an office visit and \$100.00 for a procedure visit. Emergencies are considered on an individual basis and you must contact our office to discuss this with our staff.

LATE POLICY: If you are more than 15 minutes late to your scheduled appointment, we will make every effort to work you into the doctor's schedule but this may require that you wait for other patients who have arrived on time. However, we may have no choice but to reschedule your appointment.

REQUESTS FOR MEDICAL RECORDS and COMPLETION OF FORMS: You will be assessed \$25.00 per request. Upon receipt of payment, documentation can be picked up at the office within 3-5 business days, unless otherwise notified.

BILLING STATEMENTS and DELINQUENT ACCOUNTS will not occur since payment is expected at the time of service.

CREDIT CARDS, CHECKS and CASH are accepted payments.

I have read the Financial Policy of A Children's House for Pediatric Dermatology. I understand and agree to adhere to the policies as outlined. I further agree to be responsible for all charges.

Patient name: _____ Legal representative name: _____

Signature of legal representative: _____ Date: _____

