

FINANCIAL POLICIES AND GUIDELINES

At First Coast Dermatology Associates it is our policy to provide our patients with the highest quality of care. In order for us to fully accomplish this, we must adhere to certain policies and guidelines as noted below. Please read and sign our Financial Policy prior to receiving treatment. Thank you.

* Payment is due at the time of service rendered for co-pays, deductibles, co-insurance amounts, and any other services or treatment not covered by your insurance. Please understand that co-pay, deductibles, and co-insurance amounts are determined by your insurance policy and are non-negotiable. We are required by our contract with the insurance companies to collect these monies.
* Returned checks from the bank will incur a $25.00 fee
* All appointments missed or cancelled with less than 24 hours notice will incur a $25.00 fee. Any surgeries missed or cancelled without sufficient notice will incur a $50.00 fee. Patients with more than three missed appointments may be asked to transfer their care to another dermatology practice
* Accounts with outstanding balances after insurance determination are due in full within 30 days of our statement. When an account balance becomes more than 90 days past due, it will be forwarded to an outside collection agency. Those accounts are subject to collection agency fees in addition to the balance owed. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys’ fees, we incur in such collection efforts.
* Patients with an account in collections or with unpaid missed appointment fees must pay their account in full before any more appointments will be scheduled.
* All patients under the age of 18 must be accompanied by a parent or legal guardian. The parent authorizing treatment of the child is responsible for payment at the time of service. If a divorce decree requires the other parent to pay for treatment costs, it is the responsibility of the authorizing parent to collect from the other parent.
* I authorize payment to my doctors and/or First Coast Dermatology Associates of any health insurance benefits that are payable to me.
* My signature authorizes this office to release, as well as request, information for treatment, payment, and health care operations and certifies that I have read and understand the financial policies set forth.

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Signature of patient or legal guardian Date

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Printed name of patient or legal guardian