www.dermcare.us

OUR FINANCIAL POLICY

Thank you for choosing us as your medical/surgical Provider.
We ask that you carefully read and sign the following Financial Policy

We require a copy of <u>All</u> insurance cards and ask that you present them at Each visit

PARTICIPATING INSURANCES

We participate with many insurance companies.

Co-pays are due at time of service. If a co-payment is not made at the time of service, a $5.00 service charge may be added.

NON PARTICIPATING INSURANCES AND SELFPAY

Payment in full is required at the time of service. As a courtesy, we will bill your insurance.

FOR ALL INSURANCES

Please review your benefit listing summary that you received from your insurance company to understand your coverage

MEDICAL RECORD COPY FEE

There is a fee for medical record copies in certain specified circumstances of .25 cents per page.

COSMETIC CONSULTATIONS

Our consultation fee is $125.00. We require that you provide a $50 non-refundable deposit at the time you schedule your appointment with the balance of $75.00 due on the day of your visit. Cosmetic procedures are treated as self pay. If you have surgery in the hospital setting, your consultation fee payment will be applied toward your cosmetic procedure fee.

PAYMENT METHODS

Cash, checks, MasterCard or VISA accepted. For certain situations, we will accept credit card payment plans.

NON-COPAYMENT PLANS

If your plan does not require a copay and we participate, you are responsible for any deductible and balances that your plan indicates on the explanation of benefits.

PARTICIPATING LABORATORIES

Please note that for all offices, pathology specimens are sent to Miraca Life Sciences, Inc. For the Chelmsford office, cultures are sent to Lowell General or Saints Memorial Hospital Labs. The Natick office cultures are sent to Newton Wellesley Hospital, and Arlington office cultures are sent to Mount Auburn Hospital.

We recommend checking with your insurance company regarding any limitations in your coverage for lab services.

MISSED APPOINTMENTS

Please make every effort to cancel your office visit at least 24 hours in advance or a missed visit charge of $25.00 may be assessed to you.

REFERRAL FROM YOUR PCP

If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your visit and present it when you check in for your appointment

ACCOUNT BALANCES AND COLLECTION PROCEDURES

You are responsible for timely payment of your account.

Northeast Surgery Center/Dermcare Physicians and Surgeons reserves the right to reschedule or deny a future appointment on delinquent accounts. If sent to collections, you will be required to pay reasonable attorneys fees and any expense or costs relating to the collection proceeding, including court costs

RETURNED CHECK FEE IS $25.00

I understand and agree that insurance policies are an agreement between an insurance carrier and myself. I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I authorize Northeast Surgery Center/Dermcare Physicians and Surgeons to furnish information to insurance carriers concerning my illness and treatments.

I understand that if I terminate or suspend my care and treatment, any fees including a reasonable fee as allowed by Public health law for copying of medical records will be immediately due and payable. In the event that my account balance is referred to an agency or attorneys for collection purposes, I agree to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs.

In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

(revised 05/05/16)