

OUR FINANCIAL POLICY

We are dedicated to providing the best possible care for you. Having an easily understood financial policy will keep our collective focus on your health.

1. We request a 24 hour cancellation notice. We reserve the right to charge a cancellation fee of \$25 if you do not notify us within 24 hours.
2. Any patient who misses an appointment without prior notification is considered a "no-show". After two "no-show" appointments a patient will no longer be able to make a new appointment unless a non-refundable deposit is paid in advance.
3. As a service to you, we will file your insurance claim. If your insurance company does not pay the practice within 90 days, you are responsible for paying any outstanding balances. If we later receive a check from your insurer, we will then refund any overpayment to you.
4. For patients with outstanding balances greater than 90 days, subsequent appointments cannot be made.
5. Copays must be paid on the date of service.
6. For our HMO patients- We will do our best to notify you prior to your appointment if an updated referral is necessary; however, you are ultimately responsible to make sure your referral is valid and up to date.
7. Keep in mind that while you may be receiving care in an office setting, most insurance companies consider biopsies, removals and some other procedures as a "surgical" benefit and may be subject to separate deductibles.
8. For self-paying patients, we do not accept personal checks over \$200. We accept Visa, MasterCard and American Express. There is a \$25 service fee for returned checks.
9. All patients under 18 years of age must be seen with a parent or legal guardian. A grandparent or sibling does not qualify, unless he/she is the legal guardian.

I have read and understand The Dermatology Center of Northern California's financial policy and I agree to be bound by its terms and to immediately notify the office of any changes in my insurance coverage, address and phone number. I understand that it is my responsibility to know my insurance benefits including co-payments, deductibles and non-covered services.

Signature of patient (or responsible party, if minor)

Date

Print Patient Name