ARCH DERMATOLOGY
INSTITUTE

Financial Policy

We are committed to providing the highest quality of care to our patients. The following is a statement of our financial policy, which we require you to read and sign. All copayments, co-insurance, and deductibles are due at the time of your visit. We accept Cash, Checks, Visa, American Express and Mastercard.

Please familiarize yourself with your health plan and prescription plan before you visit our office. You may require a referral from your primary care doctor, particularly if you have an “HMO”plan. If you do not obtain this referral, your insurance company may refuse to cover your visit and you will be responsible for the cost of all services.

FINANCIAL RESPONSIBILITIES:
I understand that it is my responsibility to obtain a referral from my Primary Care Physician (PCP) for all specialty services if required by my health insurance plan. If a referral is not in place prior to my visit, I acknowledge that I may be financially responsible for all services provided. By signing below, I acknowledge receipt of this financial policy and will be held financially responsible for any denied services by my insurance plan.

As a courtesy, Arch Dermatology Institute, LLC will bill claims to my insurance company for my visit and services; however, Arch Dermatology Institute, LLC has no part in the negotiations or coverage agreements in the contract between you and your insurance company. Patients should be familiar with their own insurance terms, contract, and coverage. Please be advised that it is the patient’s responsibility to verify what his or her specific insurance will cover and what it will not (co-payments, deductibles, co-insurance, and lab contracts).

POINT OF CARE COLLECTIONS/CREDIT CARD ON FILE: Payment is due at the time services are rendered. Should your account become a collection problem, the patient/ debtor assumes all costs of collection, including but not limited to collection personnel fees, court costs, interest, and legal fees. You will not be able to be seen until your collection status is resolved.

NON-COVERED SERVICES: Cosmetic services are not covered by insurance. Your payment is due at the time services are rendered. Some medical services are also not covered by insurance (treatment of benign lesions for cosmetic reasons for example).

In this case, you will be notified to the best of our ability that there's risk of insurance denial. If coverage is denied, the patient is fully responsible for the costs of the service. Cosmetic consultations are $100 due at the time of visit, but can be applied to any cosmetic service provided.

PRODUCT/SERVICES: There are no guarantees in medicine. There is no guarantee that a product or service will satisfy all of your needs. There are NO REFUNDS for products or services rendered.

CANCELLATIONS/ NO SHOWS: Arch Dermatology Institute, LLC takes the time necessary to treat all patients with the utmost courtesy and respect and makes it a priority to tend to their needs. As such, we do not overbook the schedule as many physicians do as we feel that it risks compromising the practice's priority, which is you. Your appointment time is blocked for you. Therefore, a no-show fee of $50 dollars will be charged if an appointment is not cancelled/rescheduled at least 24 hours before your appointment time. Please also note that a deposit will be required for certain procedures that require extra time or staff and your appointment cannot be booked without it for these procedures.

PATHOLOGY/LAB SERVICES: Based on what is done during your appointment, you may receive an additional bill from the pathology lab that reviewed the tissue specimen. We are unable to adjust or alter these charges or services as they are provided by a separate entity. Any issues with the charges or services on the pathology lab should be discussed directly with that entity.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY, I HEREBY AGREE TO RENDER PAYMENT IN ACCORDANCE WITH THE TERMS AND CONDITIONS SET FORTH ABOVE.

Responsible Party Signature:

_____Date: _____

Print Name:_____

Relationship to Patient: _____