Dorset Street DERMATOLOGY
where health meets beauty

Office and Financial Policies

Thank you for choosing Dorset Street Dermatology for your dermatology care. We are committed to providing you with the highest quality medical care, in an efficient, timely and cost-effective manner. Please take a moment to review our financial policy so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Insurance: Please present your insurance card when you check in and we will gladly bill your insurance company for charges incurred at our clinic. If you do not have your card, we will not be able to bill your insurance and payment for all treatment will be required at the time of service. Please remember, your health insurance is a contract between you and your insurance company. It is your responsibility to understand your coverage and benefits, including deductibles, co-insurance, referrals and pre-authorization requirements. If your insurance plan requires a referral or pre-authorization, it is your responsibility to ensure we have one on-file at the time of your visit. If your insurance deems a service to not be a covered service, you will be responsible for the balance of this service and you expressly agree to pay for such non-covered services. Claims not paid by your insurance carrier within 90 days will become your responsibility as a non-covered service. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date services are rendered.

Co-Payments, Non-Covered Services, and Cosmetic Procedures: Payment is required at the time of service. We accept cash, checks, Visa, MasterCard, Discover and American Express.

Credit Card on File: All medical patients are required to keep a credit card on file and signed authorization to charge the card for patient balances. If the credit card is denied for any reason, we reserve the right to charge an additional $25 administrative fee if we are not able to run a new credit card within 7 days. You will be contacted via phone asking for the new credit card information.

Returned Checks: A $35.00 charge will be added for any non-sufficient funds notices from the bank.

No Shows and Late Cancellations: We require advance notice of one business day if you must cancel your appointment. We reserve the right to charge $50.00 for any appointment that is not cancelled more than one business day in advance.

Collection Fee: Accounts over 90 days old will incur a 1.5% penalty per month and be forwarded to a collection agency.

Minors: A parent or guardian must accompany a minor for their first visit or provide the office with a written consent for treatment before the appointment time. A parent or guardian is responsible for providing current insurance information for the minor, placing a credit card on file for the minor's account, and providing payment in full for any co-pays, non-covered services and cosmetic procedures.

I have read the above policies and accept the terms as outlined above. I give Dorset Street Dermatology permission to release information to my insurance carrier.

Patient or Responsible Party Signature: _____ **Date:** _____

Receipt of Notice of Privacy Practices: My signature below indicates that I have received and/or reviewed a copy of my provider's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature: _____ **Date:** _____

MEDICARE PATIENTS ONLY: The office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medical claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment or benefits apply.

Signature as it appears on Medicare Card: _____ **Date**: _____

If you have a supplemental policy and it is a policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file: I authorize Medicare supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on Supplemental Insurance Card: _____ **Date**: _____