OFFICE POLICIES

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE DO NOT ROUTINELY "BILL."
We accept CASH, CHATHAM COUNTY CHECKS, and CREDIT CARDS (Visa, MC, Discover and AMEX).
I (the patient or guardian) assume financial responsibility for services rendered and agree to pay the reasonable costs and expenses incurred to collect amounts owed, including 15% as attorneys' fees and court costs. I understand that unpaid charges shall bear interest at a rate of 1.5% per month from date of service and that a service charge of $25.00 shall be applied each time my check is dishonored. If at any time I am concerned about the cost or coding of any services, I can discuss my concerns with the financial manager.

HEALTH INSURANCE

Insurance coverage is a contract between the insurance company and the patient. Responsibility for payment of fees is the obligation of each patient. If we are participating providers for your insurance company, we will file your claim. However, any unmet deductible or copay is due at the time of service. **Be aware that "COPAYS" usually cover office visits. Surgical Procedures usually fall under deductible.** If we do not "participate" with your insurance company, you will be given a statement of office services which should be sent (along with your insurance form) to your insurance company so you may be reimbursed directly.

MEDICARE

We accept assignment of benefits from Medicare. Your claim will be filed for you in accordance with Medicare regulations and payment will be accepted directly from Medicare. You are responsible for any unmet deductibles as well as 20% of Medicare's allowable charge (unless your secondary insurance is a Medicare approved Medigap). Be aware that Medicare may consider some services provided as "non-covered"/not reasonable or necessary" (i.e. cosmetic services). If such services are denied on these grounds, you are responsible for payment in full.

MISSED APPOINTMENTS

Please notify us at least **2 *working* days (i.e. M,T,W,Th,Fr)** in advance if you are unable to keep your appointment. This courtesy allows someone else to be treated - a courtesy you would want if the circumstances were reversed. If you miss scheduled appointments without **2 *working* days advance cancellation**, you will be responsible for a $50.00-$100.00 charge (for the missed visit). Higher charges will apply to no shows/cancellations without *adequate* notice for surgeries, skin cancer screening appointments, and *multiple* missed visits. You will **not** be rescheduled until the charge is paid in full. You will be discharged from the practice for repeated offenses.

PRESCRIPTION AND RECORDS/FORMS POLICIES

Hard copy prescriptions are safer, more accurate, and more likely to be filled properly. Prescriptions "called into" pharmacies are more prone to errors. We thus give hard copy prescriptions for your safety. Please do not ask us to "call in" in prescriptions (local or mail order). If you "lose" your prescriptions, you will need to come back to the office to pick up replacements. If it has been over a year since your last visit, prescriptions cannot be refilled until your follow-up visit. Prescriptions will only be refilled during office hours when your chart may be reviewed properly.
Records/Forms can be copied and\or "filled out" for a small fee depending on the type of form and size of your chart. Our office will gladly give you **one** free copy of your chart. A fee will be charged for repeated requests.

AUTHORIZATION FOR SERVICES AND RELEASE OF INFORMATION

The signature on this form serves as authorization for treatment by Chatham Dermatology. I authorize the release of any medical or other information about me/patient (including psychiatric, drug and alcohol abuse, or HIV information) to my insurance company or the Social Security Administration and Health Care Financing Administration (or its intermediaries) in order to process this or future claims or for utilization review or quality assurance. I also authorize Chatham Dermatology to release or receive medical information for the purpose of patient referral. I hereby assign benefits and authorize payment under my insurance program be made to Chatham Dermatology on any bills for services furnished to me. Regulations pertaining to Medicare and Medicaid assignment of benefits apply. I understand I am financially responsible to the physician for any balance not covered by the insurance carrier. Regarding medical care to those under age 18, parents or legal guardians are financially responsible for payment.

The signature below serves as authorization for services and release of information as detailed above. The signature acknowledges understanding and compliance with all of the above stated policies. The signature signifies assumption of full financial responsibility as detailed on this sheet. The signature below also acknowledges receipt of a copy of Chatham Dermatology Notice of Privacy Practices.

Do not sign this form until you have read it and understand it.

Date_____Signature_____

GUARDIAN OR ADULT SIGNATURE IS REQUIRED IF PATIENT IS UNDER 18.
(A copy of this signature is as valid as the original.)