

Financial Policy

**PAYMENT IS EXPECTED AT THE TIME OF SERVICE. IF YOU ARE UNABLE TO PAY
PRIOR ARRANGEMENTS MUST BE MADE BEFORE SEENG THE DOCTOR**

For your convenience we accept cash, check, Discover, MasterCard and Visa.

There is a \$25.00 charge for a returned check.

Regarding Insurances with which we participate: Blue Ridge Dermatology Associates, P.A. will file a claim with your insurance company. **You are responsible for your co-pay, co-insurance and any deductible at the time of service.** Please make sure the front of this form is completed entirely and accurately.

Regarding ANY INSURANCE POLICIES requiring referrals: Obtaining the referral for the correct dermatological problem is the patient's responsibility. **If a referral is not obtained** for the problem you wish to have addressed, **the total cost of the visit is due at the time of service.**

Regarding non-covered services: Services which your insurance company determines are not medically necessary will not be reimbursed by your insurance company. **Payment in full is due at the time of service.** Examples of such services are removal of skin tags, normal moles and benign Keratosis.

General responsibility for payment: You are responsible for payment of any office visits or procedures for which your company denies payment. We will attempt to advise you when we think a procedure might be denied. However, it is sometimes not possible to predict whether a company will reimburse prior to submitting the insurance claim. We advise, that prior to any procedure, you check with your insurance company regarding reimbursement.

Regarding insurances that we do not contract with: The total cost of the visit is due at the time of service.

Third party claims: We do not bill other parties such as financially responsible parents or employers. When a minor is present for care, the person presenting the minor is responsible for payment at the time of service.

MISSED APPOINTMENTS OR LATE CANCELLATIONS: Please call at least **one full business day** prior to your scheduled appointment to cancel or reschedule. This helps us accommodate other patients. Please be aware scheduled appointments cancelled less than **one full business day prior** to the designated time, or failure to keep a scheduled appointment, may risk a charge of a \$50 missed appointment fee (\$100 for surgery or 50% of physician cosmetic procedure fee).

COSMETIC & LASER CENTER APPOINTMENTS: Please call at least **one full business day** prior to your scheduled appointment to cancel or reschedule. Please be aware scheduled appointments cancelled less than **one full business day** will be charged a missed appointment fee of \$50. Deposits are required at the time of scheduling for appointments longer than 20 minutes in duration. A deposit of \$100 will be required for appointments longer than 20 minutes in duration, and \$250 for appointments 60 minutes or longer in duration. These deposits are nonrefundable and will be credited toward your scheduled treatment or forfeited if not cancelled or rescheduled less than **one full business day** of the scheduled appointment.

Assignment of Benefits: I hereby authorize and direct my insurance carrier (s), including private insurance, and any other health/medical plan, to issue payment directly to Blue Ridge Dermatology Associates, P.A. for services provided to myself and/or my dependents. I understand I am responsible for any amount not covered by insurance as designated by my insurance company and Blue Ridge Dermatology Associates, P.A.

Authorization to Release Information: I hereby authorize Blue Ridge Dermatology Associates, P.A., to: (1) release any information necessary to insurance carriers regarding my diagnoses and treatments; (2) process insurance claims. This order will remain in effect until revoked by me in writing. I have sought medical services from Blue Ridge Dermatology Associates, P.A. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for all charges incurred during the treatment authorized.

Your signature below indicates that you understand and accept this policy.

Signature of patient (legal guardian if a minor)

Date

Blue Ridge Dermatology Associates, P.A. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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