DERMWELLESLEY

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 charges.

FINANCIAL RESPONSIBILITY – REFERRAL REQUIREMENTS: It is your responsibility if your insurance requires one to obtain a referral from your Primary Care Physician (PCP) for all specialty services. If a referral is not in place for your visit you will be responsible for all services provided. By signing below, you acknowledge receipt of our financial policy and will be held financially responsible for any denied services by your insurance. **Initial:_____**

INSURANCE: As a courtesy to you, we will bill your insurance company for your visit and services; however, we do not share in the contract between you and your insurance company. You should be familiar with your own insurance terms/ contract/coverage. Please be advised that it is your responsibility to verify what your insurance will cover and what it will not (co-payments, deductibles, co-insurance, and lab contracts). **Initial:_____**

COLLECTIONS/CC 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. Interest on all accounts over 90 days past due will be 1% of the balance for every 30 days past 90 days. The interest will accrue on unpaid balance. You will not be able to be seen until your collection status is resolved. **Initial:_____**

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). It is your responsibility to understand whether or not any services will be covered. **Initial:_____**

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 absolutely NO REFUNDS for products or services rendered. **Initial:_____**

CANCELLATIONS/ NO SHOWS: Please see the full Cancellation policy on our website under "Patient Forms": Our goal at DermWellesley is to provide you, our patient, with exceptional, personalized care in a timely fashion. This means that we do not double book our appointment slots; rather, we block your appointment to allow you to have the highest quality, individualized time with our clinicians.Your appointment time is blocked for you. Therefore, a no-show fee or late cancellation fee will be assessed for any appointment not cancelled/rescheduled at least 24 hours before your appointment time. Please also note that a deposit will be required for certain procedures requiring extra time or staff and your appointment cannot be booked without it for such procedures. Please see our full cancellation policy on our website for more details. **Initial:_____**

PATHOLOGY/LAB SERVICES: Based on what is done during your appointment, you may receive an additional bill from the lab service provider. We are unable to adjust these charges as they are provided by a separate entity. **Initial:_____**

Please read the document entitled "Insurance Update" on our website under "Patient Forms" for a more detailed explanation about financial responsibility.

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: _____