DERMWELLESLEY

**UPDATED JANUARY 1, 2024**

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 medical 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 (CCOF):**

***Please see full CCOF policy on our website under "patient forms" and sign our consent form*

**Beginning 2024, we require an active credit card on file for all patients.** Your CCOF will be charged for any remaining balance as determined by your insurance carrier to be "patient responsibility" and will be charged automatically if you fail to pay your bill within 60 days. **If we do not receive payment, we will automatically charge your card after day 60. Late cancel/no show fees will be charged immediately (see below).** 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 as a patient until your collection status is resolved. **Initial:_____**

**CANCELLATIONS/ NO SHOWS:**

***Please see the full Cancellation policy on our website under "patient forms".*

If you are unable to keep your appointment, we kindly request **24 business hours** of notice **to cancel or reschedule your appointment**. If for any reason you fail to cancel/reschedule with at least 24 hours notice, you will be charged:

**$75 dollars for a missed medical appointment or appointment with our esthetician**
**$150 dollars for a missed cosmetic or aesthetic appointment**
**$200 dollars for a missed surgical or Mohs appointment**

Please also note that a deposit will be required for certain cosmetic procedures. **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:_____**

**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:_____**

**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 (if under 18): _____