FAMILY DERMATOLOGY of ALBEMARLE

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Conditions of Registration and Financial Policy

Patient Name:_____Date of Birth:_____

The following are our conditions of registration as well as our policies with respect to the billing and collections of your account. By signing below, you are agreeing to be bound by these terms.

- **BASIC POLICY** Payment is due in full at the time service is provided in our office.
- **FOR PATIENTS WITH MEDICARE** We will bill Medicare on your behalf. As a courtesy, we will also bill secondary insurance carriers on your behalf. You are responsible for all co-insurance payments.
- **FOR PATIENTS WITH INSURANCE** All co-payments and deductibles are due at the time of service. We will bill insurance carriers on your behalf if we have a current contract with the carrier. We will submit a courtesy claim on your behalf to insurance carriers with which we do not participate. Please be advised that your agreement with your insurance carrier is a private one and that ultimately, you are responsible for payment. If an insurance carrier has not paid a claim within 60 days of billing, our fees are due and payable from you.
- **NONCOVERED SERVICES** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial.
- **MISSED APPOINTMENTS** In fairness to other patients and the doctor, we require at least 24 hours notice to cancel an appointment. You may be charged $25.00 for each appointment that was missed or not canceled with 24 hour notice. Missing more than two appointments without providing 24 hours notice is grounds for discharge from the practice.
- **RETURNED CHECKS** There will be a fee of $25.00 charged by this office for each check returned to us by your bank.
- **COLLECTION AGENCY COSTS** In the event that your account is forwarded to a collection agency, you agree to pay an additional fee equal to 33% of the balance forwarded to the collection agency and any additional attorney fees or court costs.

MEDICARE PATIENTS: SIGNATURE ON FILE. I request and authorize payments of Medicare benefits be made to Family Dermatology of Albemarle, PLC for any services furnished me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Service and its agents any information needed to adjudicate these benefits for services. I understand my signature requests that payment be made and authorizes release of all information necessary to adjudicate the claim. If "other health insurance" is indicated, my signature authorizes the release of all information to the insurer or agency that is necessary to adjudicate the claim. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and that I am responsible for the deductible, co-insurance, and any non-covered services.

Signature:_____Date:_____

ASSIGNMENT OF INSURANCE BENEFITS. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Family Dermatology of Albemarle, PLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not the charges are paid by said insurance. I hereby authorized said assignee to release all information necessary to adjudicate all claims and secure payment for services rendered.

Signature:_____Date:_____

I have read, understood, and agree to be bound by the terms of this financial policy.

Signature:_____Date:_____