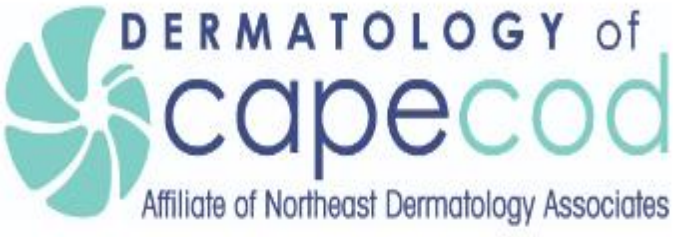

PATIENT FINANCIAL POLICY

Thank you for choosing us for your health needs. As your physician, we are committed to providing you with the best possible care. Please read our financial policy and, if you have any questions, please ask one of our associates for assistance or call our billing office at (844) 733-1400

You will be asked to show the front office staff your current insurance card at each visit. Please come prepared. This allows us to verify the information and assist you in collecting the benefits from your insurance company to which you are entitled.

PATIENTS WITH INSURANCE POLICIES:

For insurance companies that we participate with:

We are pleased to bill your insurance on your behalf. If your insurance requires you to make a copay, coinsurance, and/or deductible, we expect this payment at time of service. In addition, you will be responsible for any amount the insurance plan deems not covered, up to the entire amount.

If we do not hear from your insurance company

If we have not received payment or rejection from your insurance company in a timely manner, we will transfer the balance to your responsbility. We request your assistance in following up with your isnurance company to resolve any non-payment issues.

For insurance companies that we DO NOT participate with:

If your insurance has an out of network benefit clause and we are able to verify coverage and obtain authorization, we will submit a claim to the insurance company on your behalf. PhyNet reserve that right to collect any unmet deducitble or coinsurance at the time of service. It is ultimately the patients' responsbility to

Referrals

If your insurance requires that you have a current referral to be seen at Dermatology of Cape Cod, our policy is that you obtain one prior to your visit, otherwise you will be responsbile for the full cost of your visit contract with your insurance company. Signature: _____ Date: _____

SELF PAY PATIENTS

If you do not have sinruance or are seeking care outside of your insurance plan benefits, payment is full is required preior to the service. For your convenience, we accept cash, check, visa, mastercard, discover and american express. A returned check fee $35 will be assessed on any check returned by the bank. Future services will require payment by cash, money order or credit card

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Affiliate of Northeast Dermatology Associates

COPAYMENTS

According to the agreement you have made with your insurance company, copayments are due at each visit. If you are note prepared today your co-pay, your appointment will be rescheduled.

COINSURANCE

Coinsurance is based on the pre-determined level of coverage outlined in your insurance policy. For example, your may have an 80/20 plan, meeting the insurance will consider and pay on 80% of the charges and the remaining 20% is your responsibility. It is very important to review your coverage to determined your level of coinsurance

NO SHOW FEES

Patients who fail to keep appointments or cancel without 24 hours advanced notice may be charged a $100 fee for an visits missed with Dermatology of Cape Cod

PAST DUE ACCOUNTS

In the event a a balance becomes past due, your account will be considered delinquent. Delinquent accounts are subject to further collection action, including placement with a collection agency. The patient will be responsible for any collection fee associated with collecting the outstanding balance.

We will gladly discuss your proposed treatment and will do our best to answer any questions relative to your insurance. You must realize that: A.) your insurance is a contract between you, your employer, and the insurance company. B.) not all services are a covered benefit in all contracts. Your insurance plan may elect to not cover certain services for various reasons.

As a medical provider, our relationship and concern is with you and your health, not your insurance company. While the filing of insurance claims is a courtesy, **all charges are your responsibility from the date of services are rendered.**

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY

Signature: _____ Date: _____

Patient Name: _____ DOB: _____