Florida Dermatology Specialists

Financial and Office Policies

The practice policies below outline our expectations and options for payment.

I assign all medical and/or surgery benefits, to include "major medical" benefits, which I am entitled inclusive of Medicare and all other health payments this associated is entitled. Payment is due at the time services are provided unless other arrangements have been made. I understand you do not accept assignment in the case of liability actions.

Florida Dermatology Specialists accepts many insurance plans. However, I understand that it is my responsibility to confirm with my insurance company that the physician is currently under contract. I agree to be responsible for all copayments, deductibles, and non-covered services as determined by my insurance plan.

If my insurance plan requires a referral to a specialist, I understand that I must obtain that referral prior to my scheduled visit. If the referral is not obtained, I understand that I have the option of rescheduling my appointment or paying for the visit out of pocket.

If I am uninsured or do not have proof of insurance, I understand that full payment is expected at the time of service unless prior arrangements have been made.

I understand that I will be sent a single monthly statement followed by a reminder letter for services received. I will promptly pay all amounts determined to be my responsibility by my insurance carrier upon receipt of my statement. If my account is not paid within 90 days of the date of service, the practice may ask for the assistance of an outside collection agency. I will be responsible for any reasonable cost of collection, including credit checks, court costs, and attorney's fees. If I have any questions regarding my bill or have a financial hardship, I will call the office to make other arrangements. I understand that if my check is returned, I will be charged a fee of $35.00. Special services, such as surgical procedures and cosmetic appointments, are subject to a $50.00 cancellation fee if not cancelled with 24 hour or greater notice.

I authorize the release of medical information to my insurance carrier, any physician participating in my health care, and any physician to whom I may be subsequently referred.

Copayments are paid at the time of the visit. I am responsible to be knowledgeable of my insurance coverage, deductible, and copayments for any services provided by Florida Dermatology Specialists. I understand that I am financially responsible for payment of any services rendered to me by Florida Dermatology Specialists. I have read and accept the terms of this policy.

Printed Name: _____

Signature: _____ Date: _____