MGMD

ADVANCED SCIENCE FOR BEAUTIFUL SKIN

MGMD Dermatology ▪ Michele Grodberg MD

FINANCIAL ARRANGEMENTS

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Please ask if you have any questions about our fees, financial arrangements, or your financial responsibility.

It is important that you understand our approach to financial arrangements and by signing below you agree to comply with those arrangements.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO BEING SEEN BY THE DOCTOR.

WE DO NOT PARTICIPATE IN INSURANCE PLANS: Because we do not participate in any insurance plans, payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Should you have out of network or other insurance coverage that applies, you may submit the itemized receipt we provide to you to your carrier, along with any required forms, to request reimbursement from your insurance company to you directly.
We request a copy of your current insurance card(s) for any insurance coverage that applies to services we request on your behalf such as laboratory services.

COLLECTIONS: If your account becomes past due 120 days or greater, we will refer your past due account to our outside collection agency, and that agency's fee of 30% of the balance due will be billed to your account.

COSMETIC PROCEDURES: Insurance plans do not cover cosmetic procedures. If you request such services from us, you must pay us directly for these services at the time of the visit. If you fail to show up for an appointment for cosmetic procedures, cancellation fees will be charged to your account unless you reschedule or cancel the appointment at least 24 hours before the appointment.

You are responsible for the timely payment of your account.

WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, MASTERCARD AND VISA.

THANK YOU for taking the time to read and understand these financial arrangements.

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY NAME(print): _____

PATIENT NAME (print): _____

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