complete skin md

Patient Financial Obligation

We are dedicated to providing the best possible service to you and regard your complete understanding of your financial responsibilities as an essential element of your treatment and care.

In Network Patients: If we participate with your insurance plan, you will be responsible to pay for your co-pay, deductibles and/or co-insurance at the time of service. You may also be responsible for payment of services related to conditions that are not covered by your plan. If you have not met your deductible, you will be responsible for the amount of the deductible and whatever amounts the insurance company does not pay. If your insurance company denies payment or will only pay a portion of your medical bill, you, the patient is responsible for payment of services rendered and will be billed accordingly. Please be aware that your insurance carrier does not guarantee accuracy of its confirmation of coverage and benefits. In order to expedite this responsibility, we request that you leave a credit card on file.

Other Bills: If you should undergo a biopsy in our office, your insurance carrier will be billed separately by the Lab. You will receive a separate bill from the Lab for any uncovered charges.

Out Of Network and Self Pay Patients: Payment is due at the time of service. As a courtesy to our patients, we will submit your paid claim to your insurance carrier, It is your responsibility to follow up with your carrier regarding your reimbursement. Patients should contact their insurance companies directly for any coverage questions they may have. Sometimes the insurance company will issue payments to you, it is your responsibility to forward those payments to our office.

Missed Appointments: We require a 24 cancellation notice. If you miss your appointment, or do not cancel within the required notice, you will be charged for your missed appointment a fee of $50.00. Repeat offenders may not be reappointed.

Payment Methods: For your convenience, we accept the following forms of payment, Cash, Check, Visa, MasterCard, Discover and American Express.

I, _____ have read the above and fully understand my financial responsibility to CompleteSkinMD.

Print Patient Name: _____ Date: _____

I authorize CompleteSkinMD to charge my credit card on file for any unpaid balances. (Please present your credit card to the front desk staff so we can store the data in an encrypted secure location.)

X_____

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