

**PIEDMONT PLASTIC SURGERY AND DERMATOLOGY
FINANCIAL POLICY**

Piedmont Plastic Surgery & Dermatology believes that part of a good health care practice is to establish and communicate a financial policy to our patients. An informed and responsible patient should never have a credit problem with our practice.

PAYMENT is expected on the same day of each visit prior to the physician encounter. We accept cash, checks, Visa, MasterCard, Discover and American Express.

PAYMENT will include any unmet deductible, co-insurance, co-payment amount, prior balance, cosmetic or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.

We are participating providers for most insurance carriers. We will file all primary and secondary insurance claims for you. We do NOT file with third parties but will provide you with the information for you to do so. **Please remember that insurance is a contract between the patient and the insurance company and ultimately you are responsible for payment in full to Piedmont Plastic Surgery & Dermatology.**

Occasionally an *established* patient incurs unusually high financial responsibility for charges provided by one of our physicians. We will work with these patients to establish an appropriate payment plan and obtain a signed financial agreement.

RETURNED CHECKS will incur a \$25.00 service charge. You will be asked to bring cash or money order to cover the amount of the check plus the service charge.

ACCOUNTING PRINCIPLES – Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding charges.

DISABILITY FORMS, INSURANCE FORMS, COPIES OF MEDICAL RECORDS, ETC. require office staff time and time away from patient care for the physicians. Therefore we require 3 business days to complete the forms and requests and a fee may be charged.

Patients whose accounts have been turned over to a collection agency will be responsible for the account balance and all costs associated with collection, including attorney fees.

AUTHORIZATION / FINANCIAL INFORMATION

1. I hereby authorize the release of medical information to my insurance carriers concerning my medical condition and treatment for the purposes of claim payment.
2. I assign Piedmont Plastic Surgery & Dermatology ALL payments from my insurance carrier for medical services rendered to myself and dependents.
3. I agree that if my insurance carrier sends payment to me for the medical services instead of to Piedmont Plastic Surgery & Dermatology, I will immediately pay the amount due to Piedmont Plastic Surgery & Dermatology.
4. I agree it is my responsibility to understand my insurance benefits and to notify Piedmont Plastic Surgery & Dermatology immediately of any changes to my insurance coverage.
5. I fully understand that I am financially responsible for any co-payments, deductibles, co-insurance, cosmetic or non-covered services as determined by my insurance carrier.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____