Dermatology Associates of Coastal Carolina
2115 Neuse Blvd. New Bern NC 28560 Ph. (252)-633-4461

PATIENT FINANCIAL POLICY

Chart #_____

Patient Name:_____

Date of Birth: _____/_____/_____

Thank you for choosing our Practice! Our goal is to avoid any miscommunication or concerns regarding our Patient Financial Policy. Thus, we would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by our office.

Past due accounts of more than **120 days** may be turned over to a collection agency. Feel free to contact our Billing Services Department at **1-866-429-1213** if you have any questions regarding your account.

IN NETWORK INSURANCE PLANS:

You must present your current and valid insurance card at the time of each visit.

If we participate with an in network insurance plan under which you are covered, we will bill that carrier for all charges. We will bill both your primary and secondary insurance plans. It is not possible for our practice to know the unique benefits of your policy, so it remains your responsibility to check with your insurance company to determine your covered benefits and what your non covered responsibilities might be.

You will be responsible at the time of service for the payment of:

a. Annual deductibles.
b. Co-payments. We are required by contract to collect all co-payments in full, they cannot be billed.
c. Charges in full for all non-covered services or Cosmetic Services.
d. If your insurance carrier has not paid on your claim within **45 days** from your date of service you will automatically be responsible for the balance due.

OUT OF NETWORK INSURANCE PLANS

If we are not in network with your insurance carrier you will be responsible as a Self-Pay Patient for **ALL** costs associated with your visit on the day of service.

Your signature below signifies that you understand and accept our Patient Financial Policy and your responsibility regarding all charges incurred by you in our office.

_____ _____/_____/_____

Patient Signature **Today's Date**

2-01-16