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: _____/_____/_____

Our goal is to avoid any miscommunication or concerns patients may have 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.

24 hours' notice is required for the cancellation of any appointments. A **$50.00** charge will be applied for all **No Show** appointments or late cancellations.

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 prior to your visit.
c. Charges in full for all non-covered services or Cosmetic Services.
d. If your insurance carrier has not paid on your claim from your date of service we may require your assistance regarding your claim.
e. You may receive e-mail or text notifications.

OUT OF NETWORK INSURANCE PLANS

We will file your out of network insurance as a courtesy. However, you are responsible for any and 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**