**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 Dermatology Associates of Coastal Carolina.

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. If you have any additional questions, do not hesitate to ask any member of our team.

We value the time we have set aside to see and treat you. If you are unable to keep your appointment, we ask that you give no less than a 24-hour cancellation notice. Late cancellations and no-shows are subject to an additional fee of $50.00 dollars. We will do our best to accommodate you if you arrive more than 15 minutes past your scheduled appointment time.

Past due accounts must be settled before your next appointment. Feel free to contact our Billing Services Department at **1-866-429-1213** if you have any questions regarding your account.

## CREDIT CARD ON FILE POLICY:

To help better assist our patients with the changes in healthcare we have implemented a policy requiring a credit card held on file effective 03/01/2020. Many families have chosen high deductible health plans to help reduce cost of monthly premiums. Insurance plan's deductibles and copayments are not always known to us at the time of your visit. This feature will allow a patient's credit card information to be stored in our secure financial database. By allowing our practice to store the information, receptionists can automatically collect copays at check in as well as collecting balances due after insurance has been filed and paid their portion.

## 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 within **45 days** from your date of service, we may require your assistance regarding your claim.

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.

If you are not filing insurance at your visit you will be required to have a credit card on file. We will collect $125.00 at the time of check in and any remaining charges will be due at check out. It is possible that additional charges my accrue for pathology after your visit.

**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**