MASS DERM

Massachusetts Dermatology Associates
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PATIENT FINANCIAL POLICIES

In order to ensure smooth operation of the practice, our financial policies are outlined below:

INSURANCE: We participate in several insurance plans and will attempt to bill your insurance as a courtesy for non-cosmetic services. Additionally, we will assist you in any way we reasonably can to help you get your claim paid. It is your responsibility to provide this office with accurate insurance information and to notify us of any changes in health insurance coverage. If your insurance plan requires a referral it is your responsibility to obtain the referral and have it sent prior to your appointment. Please bring your current insurance card to every appointment.

KNOW YOUR BENEFITS: Each and every insurance company, including Medicare, has different plans, each with different benefits. Because your health insurance is an arrangement between you and your insurer, you should understand what services are covered under your specific plan. Your insurer can assist you with any questions you have related to your own benefits with them.

COPAYMENTS: All copayments must be paid at the time of service. This arrangement is part of your contract with your insurance company.

NON-COVERED SERVICES: Your Massachusetts Dermatology Associates provider may provide services that may not be covered as a benefit of your specific insurance plan. Patients or Guarantors are financially responsible for any and all services provided that are not covered. It is your responsibility to know and understand your specific insurance plan and what benefits are provided.

PRIVATE PAY/SELF PAY: Payment in full is due at the time of visit for all cosmetic services and for patients without medical insurance.

NONPAYMENT: If there is still a balance on your account after three billing cycles, the unpaid balance may be turned over to a collection agency. Patients sent to collections may be discharged from the practice unless their balance is paid in full. Patients will be notified by regular or certified mail that they have 30 days to establish alternative medical care. During that interim 30 day period, you may be treated at Massachusetts Dermatology Associates on an emergency basis only.

"NO SHOW" AND LATE CANCELLATION POLICY: If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of 24 hour notice. This courtesy on your part will make it possible to give your appointment to another patient who needs it. In the event that you are unable to give us such notice you will incur a no-show or last minute cancellation fee of $25 for general dermatology appointments and a fee of $50 for any surgical or cosmetic appointments.

OUTSIDE PATHOLOGY, LAB FEES: Biopsy, pathology and lab samples sent outside of our office are billed independently of Massachusetts Dermatology Associates. You may receive a bill from the outside lab and will be responsible for payment to that facility.

RETURNED CHECKS: There is a $30 Fee for returned checks. If your check is returned from the bank, we may not accept an additional check as payment on your account. Future payments must be made with cash, money order or credit card.

I understand that while Massachusetts Dermatology Associates physicians contract with several insurance companies, it is my responsibility to verify with my plan that the physician I am seeing is a participating provider. It is also my responsibility to verify the extent of my insurance coverage for various services offered at the practice. I further understand that it is my responsibility to obtain necessary referrals and/or authorizations required by my insurance company. If authorization is not obtained I may be financially responsible for services rendered. I acknowledge responsibility for all charges that my insurance does not cover. I also hereby assign and authorize payment of medical benefits. Payments may be made on my behalf directly to Massachusetts Dermatology Associates, P.C. for services rendered. I also authorize Massachusetts Dermatology Associates, P.C. to release necessary medical information to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered.

I have read and agree with the above Patient Financial Policies. I understand the terms and conditions outlined as confirmed by my signature:

Patient or Responsible Party's signature:_____ Date Signed:_____
Patient's Printed Name:_____
Responsible Party's Printed Name (only if applicable):_____