Financial Policy – INSURANCE PATIENTS ONLY

Thank you for visiting our office. We are dedicated to providing you with the best medical care. This document provides you with information regarding your responsibility in the insurance billing process. *Please take a few moments to read the following:*

PATIENT RESPONSIBILITY

- **You are ultimately financially responsible for the medical services you receive. We bill your insurance as a courtesy to yourself and it is your responsibility to provide us with accurate and up-to-date insurance information.**
- **If you do not have insurance coverage on the date of service, the entire cost becomes your immediate responsibility.**
- You are responsible for all denied charges, non-covered services, the annual deductible, and co-payments.
- Co-payments and deductibles are due on the day of service.
- When you are in the office for an appointment, we expect you to pay any prior outstanding balances.

CREDIT CARD DEPOSIT

- We require a credit card guarantee for all medical services effective 11/1/05.
- ***A credit card must be on file so that when you receive your explanation of benefits (EOB) from your insurance company, any balance that is patient responsibility will be charged to your credit card. If you do not have a credit card, then a deposit must be left to cover the services you have received that day.***
- Your credit card will only be charged once your insurance has processed your EOB and the amount you owe has been established. You will receive your EOB from your insurance company before we do, so you can plan for the amount to be charged. ***Should you wish to pay by cash or by check, please call the billing office at (951) 699-0303 ext.123 and speak to Pam Hayden when you receive your EOB.*** Please note that checks returned due to insufficient funds will be assessed an additional $35 processing fee.

ACCOUNT STATEMENTS

- Failure of your insurance company to pay within 90 days of filing is viewed as a refusal to pay and you become ultimately financially responsible.
- Repeated refusals to pay your balance may be referred to a collection agency or pursued legally.

Please provide us with your social security number and date of birth so we are able to bill your insurance. If our office is not provided with these information, we are unable to get paid by your insurance company which in turn makes you financially responsible for your visit.

At Total Dermatology, our main focus is medical rather than financial issues. We appreciate your understanding and your continued patronage. A copy of this financial policy can be given to you upon request.

Your signature indicates that you have read and understand our financial policy and agree to abide to it. Your signature also authorizes Total Dermatology to charge your credit card as specified by the above terms.

Signature:_____ **Date**:_____

Credit Card: (please check one) ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Cardholder's Name:_____

Card Number: _____ Expiration Date:_____