FINANCIAL POLICY(Part 1)

Thank you for choosing MetroDerm, P.C. for your healthcare needs. We are committed to providing the best dermatologic and plastic surgical care possible. Please understand that payment of your bill is considered part of your treatment. The following statement explains our Financial Policy which we ask you to read, sign at the bottom of each page, and return to us prior to your treatment. Please contact our Billing office if you have any questions or concerns at (404)257-9933.

1. **FINANCIAL AGREEMENT** I hereby assume full responsibility for all charges incurred for professional service rendered by MetroDerm, P.C., unless the service is deemed "paid in full" as a result of a contractual agreement between MetroDerm, P.C., and my insurer. I understand Metroderm can only provide general information regarding provider participation in my specific plan and that it is up to me to verify participation, referral requirements, and benefit details with my insurance carrier prior to my appointment. I understand that MetroDerm can NEVER guarantee coverage for any service provided due to the fact that insurance companies will not guarantee benefits until they receive claim for said services; therefore, If you are unsure of your coverage benefits, you should call the customer service number on your insurance card.

2. **AUTHORIZATION FOR RELEASE OF INFORMATION** I hereby authorize MetroDerm, P.C., to release any medical, psychiatric, infectious disease (including AIDS confidential information) or drug and/or alcohol related information to my referring physician and any insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that this action has been taken in reliance hereon.

3. **GROUP & INDIVIDUAL INSURANCE, ASSIGNMENT OF BENEFITS** I authorize my health insurance benefit plan to pay directly to MetroDerm, P.C., the surgical and/or medical benefits. If any, otherwise payable to me for their services as described on attached claim but not to exceed the changes for those services. I understand I am financial responsible to MetroDerm, P.C., for charges not covered by this agreement.

4. **MEDICARE, CLAIM AUTHORIZATION AND PAYMENT REQUEST** I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration for its intermediaries or carrier any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request of medical insurance benefits to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

-All applicable co-pays, deductibles, and prior balances are due at the time of service.
-We accept cash, checks and all major credit cards.
-**We DO NOT accept checks for cosmetic procedures or cosmetic products**.

Signature:_____ Date:_____

FINANCIAL POLICY (Part 2)

5. **REGARDING INSURANCE** We participate with Medicare and most insurance plans. However, you must realize that your insurance is a contract between you, the insurance company and/or your employer. While we may be a provider of services, we are not party to the contract. It is imperative that complete personal information and a copy of your current insurance card is provided prior to being seen to ensure accurate billing. PLEASE NOTE: If incorrect insurance information is given by the patient or patients guarantor, any denial or unpaid claim will be the financial responsibility of the patient. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary. In these instances, you will be responsible for these amounts. Some Policies have deductibles for surgical procedures. The insurance companies consider procedures like cryosurgery (freezing with liquid nitrogen), removal of moles, or other small procedures as "surgery". If you have a surgical deductible that has not been met and have one of these procedures, you will be responsible for payment at the time of service.Please be aware that any amount collected from you at the time of service is just an estimate. Final patient responsibility is determined by your insurance carrier and you will be billed for any responsibility left to you by your insurance carrier less any payments made by you towards your visit.

6. **MISSED APPOINTMENTS** Please help us to serve you better by keeping scheduled appointments. Appointments must be canceled at least 24 hours in advance. Please be aware that if you no-show for your appointment, or cancel your appointment within 24 hours of your scheduled appointment, you will be charged a $50.00 fee.

7. **PAYMENT DUE** Be advised that we require payment in full within 90 days of the receipt of the explanation of benefits from your insurance company. Our practice does understand that medical bills at time can be burdensome. If you need more than 90 days to pay your balance you must contact our office to make a payment arrangement. You will be required to provide a credit/debit card that can be auto-drafted each month to secure payment. Any balance past 90 days due without a secured payment arrangement on file will be considered overdue and will be subject to collections. Please be advised that recurring payment arrangements are subject to approval and the length of duration is dependent on the amount owed. The maximum duration for any balance may not exceed 12 months.

8. **PAST DUE ACCOUNTS & RETURNED CHECKS** It is understood that Overdue accounts will be turned over to a collection agency. A $50.00 processing/filing fee as well as a fee of 40% of my balance will be added to my account. EXAMPLE: $200 owed + $50 processing + $80 (40%) = $330. Checks returned to us as unpaid by your bank, we will charge a $45 fee.

I _____have read the Financial Policy. I understand and agree to the Financial Policy:

Signature_____Date_____

Johnson Ferry
875 Johnson Ferry Rd NE Ste 300
Atlanta, GA 30342

Paulding
148 Bill Carruth Pkwy Ste 280
Hiram, GA 30342

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