DERRINGTON Dermatology

Dr. Sarah Derrington, M.D.

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Patient Financial Policy

Derrington Dermatology requires that you pay your financial responsibility at the time services are rendered.

Derrington Dermatology will gladly file your insurance claim for you. We do ask that you provide us with the necessary information to do this. We will need a copy of your insurance card to be sure we have the correct insurance billing information. If a billing problem arises, we may ask you to provide (verify) additional information concerning your coverage. It is the responsibility of the patient to notify Derrington Dermatology of any changes in coverage. WE MUST OBTAIN AN UPDATED PATIENT INFORMATION FORM WITH A SIGNATURE EVERY 6-12 MONTHS

For patients with insurance plans for which we are a contracted provider, the appropriate co-pay, deductible, co-insurance, and charges for any non-covered services will be collected at the time of service.

For patients who are covered by insurance plans in which our physicians are not contracted providers, you will be required to pay 50% of the charges at the time of service. After we file the claim and receive payment, you will be billed for any unpaid charges regardless of the benefits and payment policies of the plan.

For Self Pay and patients having a service provided that is not covered by insurance, all charges will be collected at the time of service

For elective cosmetic procedures, payment is due 5 business days prior to the procedure. We accept cash, check, VISA, MasterCard, Discover, Amex.

No Show Fees

A $50 no show fee for scheduled appointments will be charged. Any cancellations or rescheduling of appointments must have at least 48 hours notice to avoid the $50 fee.

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Credit Card Payment Policy: **It is Our Policy** to keep a method of payment on file, whether it be your debit or credit card, to be used for the portion of services that your insurance does not cover, but for which you are financially responsible. You will receive a courtesy call informing you of any outstanding balance and pending charge to your card.

Please choose an option below:

☐ **Credit/Debit Card used at today's visit**

Last four digits of card_____ **Zip Code**_____ **CVV**_____

Amex ☐ Visa ☐ MasterCard ☐ Discover ☐

Card number:_____

Expiration Date:_____ CVV_____

Billing Address:_____

City:_____ State:_____ Zip Code:_____

I, _____, authorize and request Derrington Dermatology to charge my credit card, indicated above, for balanced due for services rendered that my insurance company identifies as my financial responsibility.

_____
Patient Name (PRINT)

_____
Patient Signature

_____
Date