SANOVA
DERMATOLOGY

FINANCIAL POLICY

Thank you for choosing Sanova Dermatology! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

Please initial next to each paragraph as well as sign at the bottom of this page

_____**Insurance-Claims.** If we participate with your managed care or commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for the payment of:

- The copayments and annual deductibles
- Charges for non-covered or cosmetic services

We will call your insurance company to verify eligibility and benefits. However, verification of benefits is not a guarantee of payment. You will be billed a balance if:

- Your insurance company pays less than what we expected
- We obtain a denial from your insurance company
- We have not received payment from the insurance within 60 days of our filing the claim

Please be advised that anything you choose to have removed, biopsied, or injected may not be covered under your office co-pay and might be excluded from coverage or subject to your deductible. We will make every effort to contact your insurance company to verify your benefits, but in the event we are unable to reach them, you will be responsible at the time of service for your co-payment as well as payment for procedures performed. Such procedures include but are not limited to biopsies, injections, removal of warts, moles, pre-cancers, skin cancers, or other skin lesions. Methods of removal may include but are not limited to: cutting, freezing, burning or application of a blistering agent.

_____ **Authorization/Financial Responsibility**. I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and responsible for obtaining referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Sanova Dermatology, PLLC for services rendered to me.

_____ **Medicare**. We are Medicare participating providers, therefore we will bill Medicare directly. You will be responsible at the time of service for payment of:

- The copayments and annual deductibles
- Charges for non-covered or cosmetic services

You will be asked to sign a Waiver of Liability in the event a service is provided that is not covered by Medicare.

_____ **Patients-Without-Insurance-Coverage-or-Out-of-Network-Coverage**. Payment is due for all services on the day they are rendered.

_____ **Returned Checks**. There will be a $25.00 service fee charged to your account if your check is returned for any reason. Upon notification from our office, payment of the entire balance is due immediately.

_____ **Skin Care products**. If you purchase skin care products/supplies from our office, please understand that these items are a non-refundable. If the product/supply is defective, we will gladly replace the item(s).

_____ **No Show Policy**. We kindly request that you give us 24 hours notice if you are unable to keep your appointment. Failure to give 24 hours notice will result in a $35.00 missed appointment fee. This fee is not covered by your insurance plan.

If you have any questions, please do not hesitate to ask us. We are here to assist you any way possible.

Your signature below signifies that you understand our financial policy and policies listed above, your responsibility regarding charges incurred in this office, and have read and reviewed all of the above notices.

_____ _____

Patient Signature Date