**BALA DERMATOLOGY**


## Financial Policy

*Bala Dermatology* believes that communicating our financial policy is good healthcare practice. Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and us. We will file your primary and secondary insurances as a courtesy. Please realize that having secondary insurance does not necessarily mean that your services are covered 100%. Secondary insurances typically pay according to a coordination of benefits with the primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur. **You are responsible for all copays, coinsurance, deductibles, and non-covered services**. **We are obliged to collect your copay at the time of service per your insurance company.** We accept cash, debit card, check, MasterCard & Visa. Statements are sent out monthly, and we ask that balances due be paid when you receive your statement or at your next appointment, whichever is sooner. Patient payments are typically applied to the oldest balances first, except for copayments and coinsurances – they are applied to the current date of service.. When you receive healthcare services from us and we bill your insurance, it is the same as though we are extending you credit. You receive the service and we await payment from you and/or your insurance. Due to the high cost of rendering care and the lowering reimbursements by many insurers, including Medicare, we simply cannot afford to carry large balances. Please understand that we cannot waive deductibles, coinsurance and copays that are required by your insurance. This is a violation of our contracts with the insurance plans. **We kindly request at least 48 hours notice for any appointment cancellations, or a fee may be assessed.** I understand and agree to the *Bala Dermatology* Financial Policy.

**Patient Name (print)**: _____ **Date**: _____

**Patient Signature**: _____

**Patient Representative:** _____ **Date**: _____

**Relationship to patient:** _____