**Thank you for choosing Atlanta West Dermatology & Surgery Center as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you carefully read and sign this form to acknowledge your understanding of our financial policies.**

**\* The patient is ultimately responsible for the payment of service. If the patient is a minor, the parent/legal guardian who accompanies the child to the initial appointment and signs forms is the guarantor, regardless of who provides insurance coverage or of divorce situations.**

***We are contracted with many insurers and health plans including Medicare to accept assignment of benefits. This means we will bill those plans for which we have an agreement with and will only require you to pay the authorized copayment at the time of service. However, you will be billed for any deductible, co-insurance and non-covered services after your insurance has processed the claim. Payment is due upon receipt of a statement from our office.***

**\* We are pleased to assist you by filing to your insurance, however, the patient is required to provide us with the most correct and updated information about their insurance. The patient will be responsible for any charges incurred if the information provided is not correct or updated.**

**\* The patient is responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service for copayments, cosmetic services, products, as well as payment in full for any non-insured persons.**

**\*Patients may incur and are responsible for payment of additional charges at the discretion of the practice. These charges may include (but are not limited to)**

**- *Charges for returned checks, $35.00.***

***- Charges for missed appointments without 24-hour advanced notice, $50.00.***

***- Charges for non-emergent after hours calls, $50.00.***

***- Charges for copying and distributing medical records, there is no charge for these items if accessed via your patient portal.***

***- Charges for FMLA and like forms $10.00-$50.00***

***- Service fee of $15.00 for any/each account placed with an outside collection’s agency***

**\* If your insurance requires a referral, it is your responsibility to provide the referral to our office prior to seeing the physician. If you are unable to provide the referral prior to the scheduled appointment, payment in full will be required at the time of the visit or you may reschedule your appointment.**

**\* If you have Medicare PART B you are responsible for your Medicare deductible and your 20% co-insurance. If you have secondary coverage, we will file this as a courtesy to you.**

**\* Coordination of Benefits (COB) is the order in which claims are to be filed when someone is covered by more than one insurance for payment to be eligible. It is your responsibility to be in contact with each of your insurances to be sure your COB is up to date and to inform us of which order to file your insurances. In the event that one or more of your insurances deny payment due to COB, you are responsible for full payment of services provided.**

**\*Our office does NOT bill preventative services therefore please know you will always be responsible for a co-pay, deductible and/or co-insurance for any appointment in our office even if only for a “skin screening”**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_**

**Print Name of Patient Signature Date**