

# Patient Financial Policy

Dermatology Associates of West Michigan

**PLEASE INITIAL AND SIGN WHERE INDICATED**

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Initial

Your complete understanding of your financial responsibilities is a key element in providing our services. Co-pays, co-insurance and deductibles are your responsibility.

**If you have any questions about your insurance coverage, you must contact your insurance company *prior* to your appointment.**

**You are required to show the following at each visit:**

- Drivers License or State Picture ID
- Current Insurance Card(s)

**A parent or guardian is responsible for expenses incurred for any patient under the age of 18.**

**PLEASE READ NEXT STATEMENT CAREFULLY**

There will be a **separate charge for lab work** done in our office and/or in an outside laboratory. You may receive a **separate statement** for any amount not paid by your insurance.

\_\_\_\_\_  
Initials\*

**Patients With Insurances We Contract With:**

- Co-pays are required at the time of service. If you are unable to pay, your appointment will be rescheduled.
- If your insurance company has not paid a claim within 45 days you will be responsible for payment.
- Please note: "Covered" by your insurance policy does not necessarily mean "Paid in Full"

\_\_\_\_\_  
Initials\*

**Patients With Insurances We Do Not Contract With OR Self Pay Patients**

- Payment in full is required at the time of service.
- As a courtesy to you, we will file a claim with your insurance company if you provide us with your current insurance information
- If you anticipate substantial costs for your treatment, we work with a financing company that may be able to finance your procedure prior to your appointment. If you are interested, please contact our Billing department at 616-575-6894.

\_\_\_\_\_  
Initials\*

**We accept cash, check, money order, credit, or debit cards.**

Returned Check Fee is currently \$35

**I have read and understand the financial policy of Dermatology Associates of West Michigan and agree to its terms. I understand that such terms may be amended by the practice at any time.**

➤ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Patient or Responsible Party\* Date\*  
(typing full name serves as an electronic signature)

(\*Denotes a Required Field)

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