Patient Financial Policy
Dermatology Associates of West Michigan

PLEASE INITIAL AND SIGN WHERE INDICATED

In order to promote understanding between our patients and the practice, we have implemented the following financial policy. If you have any questions about the policy, please ask to speak with someone from our Billing department. The Billing department phone number is 616-575-6894. We are committed to providing the best possible care and service to you, and your complete understanding of your financial responsibilities are a key element in providing that service. If you have questions about whether or not we participate with your insurance please contact our office *prior* to your appointment. For questions about your insurance coverage please contact your insurance company *prior* to your appointment.
It is always best to ask questions about your insurance coverage prior to having services performed.

- ✓ A driver's license is required to be shown at your visit to verify that we are providing services to the appropriate person and protect our patients from identity theft.
- ✓ For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor on the first visit responsible for expenses incurred.
- ✓ If you fail to notify us of an insurance change you will be fully responsible for any amount not paid by your insurance company.
- ✓ **Returned Checks:** There is a fee (currently $35) for any checks returned by the bank.

PLEASE READ NEXT STATEMENT CAREFULLY

Commonly, in this practice, we perform procedures that require lab work. There will be a **separate charge** for this lab work from one of our physicians, our on-staff Dermatopathologist, or potentially from other collaborating laboratories. Your insurance will be billed and a **separate statement** will be sent to you for any amount not paid by your insurance.

______ INITIALS

Patients With Insurances We Contract With:

- Co-pays are required at the time of service. We accept cash, check, money order, credit, or debit cards.
- You are responsible for payment in full at the time of service for any for any services that your insurance does not cover.
- We will file an insurance claim with your insurance company if you provide us with your current insurance card at your visit. If your insurance company has not paid the claim within 45 days you will be responsible for payment.
- Your insurance policy is a contract between you and your insurance company in which the doctor is not involved.
- You will be responsible for any co-insurance or deductibles that your insurance requires.
- Please note: Because a service is "covered" by your insurance policy does not necessarily mean that your insurance company will pay for the service. Many insurance policies have deductibles that need to be met before they will pay for services. If you are unsure if you have such a policy, please contact your insurance company *prior to your visit.*

______ INITIALS

Patients With Insurances We *Do Not* Contract With:

- Payment in full is required at the time of service. We accept cash, check, money order, credit or debit cards.
- If you provide us with your current insurance information we will file a claim with your insurance company as a courtesy.
- If you have received authorization for services to be performed at our practice that are not normally covered by your plan, please note that payment is still due *at the time of service* and we will file a courtesy claim for you.

______ INITIALS

Self-Pay Patients:

- Payment in full is due at the time of service. We accept cash, check, money order, credit or debit cards.
- We do not accept payment plans.
- If you anticipate substantial costs of your treatment, we work with a financing company that may be able to finance your procedure *prior* to your appointment. If you are interested in financing a larger balance please contact our Billing department at 616-575-6894.

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 if Minor **Date**

► ____

Printed Name