BROWN DERMATOLOGY
BROWN PHYSICIANS, INC.

Financial Policy and Patient Responsibilities

PATIENT NAME:_____ DOB: _____

Thank you for choosing Brown Dermatology, Inc. as your medical provider. The following is a statement of our Financial Policy and Patient Responsibilities, which we require you to read and sign prior to receiving any services.

Insurance

Our practice participates with most health insurance plans. Insurances vary in their coverage and it is the patient's responsibility to understand his/her medical benefits. Please bring your insurance card and a photo I.D. with you at the time of your appointment, it will be copied and the information entered into our system. This is to ensure that the information we have is correct and that your insurance plan is current. If there are any issues concerning eligibility, coverage policies, or other problems not related to our billing practice, you will be responsible for all charges incurred

Insurance Referrals

You are responsible for all referrals required to comply with your insurance plan. Please obtain your Primary Care Physician's referral prior to your appointment if required by your insurance carrier. If your claims are denied for lack of referral or if the referral is rejected by your insurance company, you are responsible for all charges.

Co-Pays, Deductibles, Co-Insurance, & Self-Pays

All office co-pays, deductibles, co-insurance, and self-pay visits are to be paid at the time of service. Please check with your insurance company to determine the amount of your plan deductible. We accept cash, check, Visa and MasterCard. A $15.00 fee may be applied if the co-pay is not paid at the time of service. If you are unable to pay your balance in full, we will gladly arrange a payment plan. Arrangements must be made with our Billing Department prior to your appointment.

The following fees will not be filed with your insurance carrier; they are the direct responsibility of the patient:

No-Show Fee

Any patient who does not show for their scheduled appointment and has not called with 24 hour notice to cancel the visit may receive a $35 "no show" charge. Payment is due upon receipt of statement and no further appointments may be made until the charge has been paid.

Returned Check Fee

There is a $30 returned check fee.

I have read, understand, and agree to the financial policies as outlined

Your signature below indicates that you understand and acknowledge the financial responsibility for services rendered by Brown Dermatology, Inc. Further, your signature authorizes Brown Dermatology to release such medical information necessary to process your insurance claims.

Print Patient Name:_____ Date:_____

Signature of Patient or Responsible Party: _____