Advantage Dermatology, P.A.
1514 Nira Street • Jacksonville, Florida 32207 • Phone: 904-387-4991 • Fax: 904-384-3613

Financial Policy

It is the policy of Advantage Dermatology, P.A. to provide our patients with access to the highest quality dermatological care available. We ask that you read, understand, and sign our Financial Policy prior to receiving treatment.

PAYMENT AT TIME SERVICE

We will bill your insurance for all services; however, we require that you pay any portion of your costs not covered by your insurance due to deductibles, co-insurances or co-payments on the day of service. Billing for these items is not only costly, but our statements often go unpaid. This results in increased costs to all patients.

PREPAID COSMETIC SERVICES

Prepaid cosmetic services are non-refundable.

SUBMISSION OF CLAIMS

Your health insurance plan is a contract between you and your insurer. Charges not paid by your insurance company are your responsibility, as a courtesy we file claims to the insurer. We can work together to resolve most insurance issues in a mutually acceptable manner. The patient is responsible for understanding his or her policy limitations. In the event your health insurance determines that a service you have received is not covered, you will be responsible for payment.

OUTSTANDING BALANCES

We urge you to keep your account current. When an account balance becomes more than 90 days past due, it will be referred to collections. Any additional fees incurred on the account will be the responsibility of the patient. If you need to make special payment arrangements, it is your responsibility to contact one of our billing managers before your account is sent to collections. Patients who fail to make payments could be discharged from the practice.

PAYMENT OPTIONS

You will receive monthly statements. The amount showing in the "Please Pay" section is your financial obligation. It is due and payable upon receipt. For your convenience, we accept payment in the form of cash, check, Visa, MasterCard, American Express and Discover. Payments may be called in at (904) 387-4991, or mailed to PO Box 743232, Atlanta, GA 30374-3232.

RETURN CHECK, NSF, CLOSED ACCOUNTS

Payments made to Advantage Dermatology, P.A. that are not honored by the bank will incur a return check fee of $50.00. Failure to submit new payment with the fee included within 15 days of receiving the return check notice from Advantage Dermatology, P.A. could result in the account being turned over to the State Attorney's office. All future payments will need to be made in the form of credit card, money order or cash.

NO-SHOW FEE

Appointments cancelled without 24 hours' notice will be assessed a no-show fee.

- $50.00-Clinical
- $50.00-Cosmetic
- $100.00-Surgery

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Financial Responsibility

I understand that I am financially responsible for all services rendered. I understand that it is my responsibility to confirm my insurance coverage with my insurance carrier ***prior*** to my visit. I understand that I am responsible for all applicable copayment, coinsurance, deductible, and payment for non-covered services. I have been offered a copy of Advantage Dermatology, P.A.'s Financial Policy.

I understand that if I am covered by an insurance carrier that requires a referral or authorization from my primary care physician or insurance carrier, it is my responsibility to obtain that referral/authorization prior to my visit. If my insurance carrier requires direct contact with Advantage Dermatology, P.A. to authorize a referral/authorization, I will inform Advantage Dermatology, PA of this requirement ***prior*** to my visit.

I understand that I will be charged a no-show fee for appointments cancelled without 24 hours' notice. The no-show fee is $50.00 for clinical appointments, $50.00 for cosmetic appointments, and $100.00 for surgical appointments. I understand that prepaid cosmetic services are non-refundable.

Assignment of Insurance Benefits & Payment Responsibility

I permit the named insurance carrier(s) to provide payment of my insurance benefits, if any, directly to Advantage Dermatology, P.A. for services rendered by Advantage Dermatology, P.A. to me during the course of my examination and treatment. I understand that I am responsible for payment for all non-covered services.

Information Release

I authorize Advantage Dermatology, P.A. to release my insurance carrier or to the Social Security Administration and Health Care Financing Administration any information needed to determine benefits payable to the related service(s). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Advantage Dermatology, P.A. Regulations pertaining to Medicare assignment of benefits also apply.

Medicare and Medicaid Participation

Our practice is a participating provider of the ***Medicare*** program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-insurance. We do file secondary/supplemental carriers. However, in the event that the secondary carrier does not pay within (sixty) 60 days, patients will be billed the balance.

Advantage Dermatology, P.A. is ***not*** a Florida ***Medicaid*** provider. I understand that claims will ***not*** be submitted to Medicaid. I also understand that I will be responsible for all charges that otherwise would be covered by Medicaid, if Advantage Dermatology, P.A. was a Florida Medicaid provider.

Notice of Privacy Practices

I have been provided a copy of Advantage Dermatology, P.A.'s Notice of Privacy Practices. I understand that I may print an additional copy at any time and that this Notice is available on the practice's website.

My signature below indicates my understanding and agreement to the above statements.

Signature: X _____ **Date:** _____

By parent or guardian if patient is a minor