New Age Dermatology Financial Policy
Year 2022 Onward

1. Out-of-Network / Non-Contracted Insurance Plans / Self-Pay:

Payment is expected up front for all office visits and procedures if you are covered under an insurance that we currently do not participate with, or if you are self-pay. In the event that a personal check is returned to us uncollected from your bank, your account will be assessed a $25 returned check fee.

2. In-Network / Contracted Insurance Plans:

If we participate with your insurance plan, we will bill your insurance company for all charges for services rendered. You will also be responsible for any balance remaining after your primary and/or secondary insurance plan has paid, and we have taken the contracted adjustment.

We expect payment up front for any / all of the following as they apply to each individual:

I. Deductible II. Co-payment III. Charges for all non-covered services or cosmetic services

Referrals: If your insurance plan requires a referral from a primary care doctor, it is **your responsibility** to obtain and provide to us that referral before your scheduled appointment with us. If you have not done so at the time of your visit, you will be responsible for all charges for services rendered if not paid by your insurance company.

Although we put forth every effort to notify patients of charges commonly denied as non-covered services, it is impossible for us to determine what each individual plan may or may not cover. You will be responsible for payment of any charges deemed not covered by your plan.

Typical Billing Process once a Claim has been Filed: If we do not receive a response from the insurance carrier after 60-90 days, you will receive a statement, and you should then contact your insurance company regarding payment. Any balance remaining after 90 days will be the patient's responsibility. After 120 days from the original date a claim has been filed, we reserve the right to place accounts with an outside collection agency.

3. Missed and Canceled Appointments:

When we schedule appointments, we set aside time and resources to meet a patient's needs. When a patient fails to show up for their appointment, or fails to cancel at least 48 hours before the appointment time, other patients that need medical care are unable to be seen, as that appointment time was held for the scheduled patient. Out of consideration for other patients needing appointments, and also our physician and staff's time, please make every effort to keep an appointment.

Please give at least 48 HOUR NOTICE to cancel or reschedule your appointment.

APPOINTMENTS NOT CONFIRMED AT LEAST 48 HOURS BEFORE THE APPOINTMENT TIME MAY BE RELEASED. Appointments may be confirmed through the automated text appointment reminders, or automated email appointment reminders. Please make sure we have either an email, and/or mobile number on file, if you would like to receive appointment reminders.

However, if you need to cancel/reschedule instead, please do NOT reply to any automated texts appointment reminders, do NOT reply to automated email appointment reminders, to cancel/reschedule – because these are automated we will not see them. Please CALL us and/or leave a voicemail to cancel/reschedule.

I am aware and understand that New Age Dermatology may enforce a 48-hour notice requirement for appointment cancellation/rescheduling. I further understand failure to notify the office at least 48 hours prior to my scheduled appointment may result in an assessment of a **$55** fee to my account. These fees are not payable by my insurance.

COVID-19 and Cold/Flu Cancellations: If you've tested positive for Covid-19, and/or you're having to self-isolate, and/or are symptomatic (fever, vomiting, coughing, etc) – **please help protect our patients and staff by canceling your appointment asap.** We will gladly reschedule and waive any late cancellation fees in these conditions.

4. I, the undersigned, voluntarily consent to medical treatment under the professional judgment of the on-site physician and staff. I understand that the medical treatment performed is necessary or beneficial to my condition. I acknowledge that no guarantees have been made to me as to the effects of such examination or treatment. By signing this form below, I understand the financial policy, and my responsibility regarding charges incurred in this office.

Signature of Patient or Responsible Party _____ **Date** _____

Revised 04/20/2022