FINANCIAL POLICY

This document provides you with the Financial Policies used by Embrace Dermatology and Aesthetics, LLC. Your signature and initials are required on this form in order to be seen by any of our providers. If you have any questions, please ask a staff member.

Please read and initial the following specifics regarding our payment and collection processes.

____I understand I will be responsible for any remaining balance not covered by my commercial insurance company, Medicare and/or my supplemental policy.

____I understand that procedures performed in the office are often separate billable services that are not included in the office visit. I understand that many insurance companies apply these procedures to a deductible or co- insurance and may not be covered under the co-payment. It is my responsibility to know and understand what my policy benefits are with my insurance company.

____I understand that if I have a surgical procedure or biopsy done at Embrace Dermatology and Aesthetics, LLC, there are two charges. First is the provider charge for collecting the Biopsy and the second is a charge to examine the specimen by a Pathologist. Because Pathologists are also medical doctors, I will be billed separately for these pathology charges based on my insurance policies.

____I understand that my insurance company may have a preferred laboratory for labs and pathology. It is my responsibility to know which preferred laboratory company I need to use. It is my responsibility also to inform my provider of this at the time services are rendered.

____I understand that a $30 returned check fee will be assessed to my account for any checks returned by my financial institution. I also understand that payment of the check and fee will be due immediately and I will no longer be able to issue a check as payment to the practice.

____I understand that my provider might request a second opinion for my biopsy results. This pathologist might not be participating with my insurance company. I understand the charges are my responsibility if my insurance company does not cover the pathologist's services.

____I understand if I do not have health insurance I am responsible for payment in full at time of service

____I understand if I am receiving a cosmetic procedure I am responsible for payment in full at time of service.

____I have read the above stated financial policy and agree to meet my financial obligation in accordance with this policy.

Consent to Pay for Services Rendered: Our doctors accept Medicare and many commercial insurance plans. Medicare will forward claims to most secondary payers. If we are contracted providers (in-network) with your insurance plan, we are required by contract with your insurance company, to collect your co-payment(s) at the time of service. For patients with private insurance with whom we have no contract (out-of-network), you will be required to pay for your services at the time of service. It is your responsibility to verify with your insurance plan if we are a contracted provider and to understand your coverage benefits under your policy. Insurance coverage is not a guarantee of payment by your insurance company. If your insurance company fails to respond or does not pay promptly, we will forward the balance to you for payment. Should your insurance company pay after you have already paid us, we will promptly refund you any overpayment due to you . We accept Visa, MasterCard, Discover and American Express for your convenience.

Print Patient Name _____ Date of Birth _____

Signature of Patient or Responsible party_____ Date:_____

EMBRACE DERMATOLOGY AND AESTHETICS, LLC
123 Chestnut Street, Suite 300
Philadelphia, PA 19106
909 Sumneytown Pike, Suite 105
Spring House, PA 19477
Phone: 267- 609- 2424 Fax: 267-609-2425