**ALPINE DERMATOLOGY ASSOCIATES**
**FINANCIAL POLICY**

Welcome to Alpine Dermatology. In order for us to be able to deliver the quality of care that you are accustomed to, we have established these financial policies. The following is a list of guidelines that are necessary in order to continue to provide high quality of care and make your visit as pleasant as possible.

**PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY INITIALING AND SIGNING BELOW.**

When asked, and as a courtesy to you, we will try to give you general guidelines about what your insurance might cover. Since medical insurance is an agreement entered into by you and your insurance carrier, **YOU ARE ULTIMATELY RESPONSIBLE FOR KNOWING THE SPECIFICS OF WHAT YOUR POLICY COVERS.**

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address or telephone numbers, please notify the receptionist and we will give you a form to update.
3. We will collect your deductible, co-payment, or charge for non-covered services at the time of your visit. My copayment for each visit is $_____. My annual deductible is $_____ of which $_____ has been met for this year. If you have a balance after an insurance payment from a previous visit, we will also ask for that payment. We accept cash, checks, Visa, MasterCard, and Discover. _____(please initial)
4. MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all your *covered* charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within *60 days* of being submitted, we will bill you for the balance due. If you do not have supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. You will be responsible at the time of service for payment of annual deductibles, copayments, charges for noncovered or cosmetic services* _____(please initial)

   ***You will be asked to sign a Waiver of Liability form in the event that service is provided which we know is not, or have reason to believe may not be, covered by Medicare.**
5. HMO-PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of service – *no exceptions.* If we do not participate with your plan, we will provide you a receipt to file with your insurance company and full payment will be expected at the time of service. _____(please initial)
6. SELF-PAY PATIENTS: Patients with no insurance will be expected to pay in full at the time of service – *no exceptions*. _____(please initial)
7. NO SHOW OR MISSED APPOINTMENTS: When an appointment is scheduled with the doctor, time is specifically allocated for you. When an appointment is not cancelled in advance, and the patient "no shows", another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there *may* be time when you are unable to keep an appointment, but we ask the courtesy of a phone call at least 24 hours in advance to cancel or change your appointment. We reserve the right to charge for missed appointments or appointments cancelled without 24 hours advance notice. _____(please initial)

I have read and have a full understanding of the financial policy of Alpine Dermatology Associates.

Signature: _____ Date:_____