ESTERSON DERMATOLOGY

FINANCIAL POLICY

We appreciate your confidence in choosing Esterson Dermatology. Please take a moment to review the important financial information below.

We accept the following forms of payment: Cash, Check, MasterCard, Visa, Amex, or Discover. We are contracted providers for Medicare, Blue Cross Blue Shield, Aetna, Cigna, United Healthcare, Great West, Coresource, Johns Hopkins, PHCS,Coventry Mutual of Omaha, Banker's Life, Tricare, and GEHA.

With certain insurance policies you are required to have a referral in order for your medical services to be covered. It is your responsibility to know if a referral is required and to obtain authorization for services you wish to have rendered.

__I understand that office visit charges are payable on the day service is rendered. I authorize Esterson Dermatology to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Esterson Dermatology and myself. I understand that the cosmetic charges are payable on the day service is rendered. I understand that Esterson Dermatology will charge me a no-show fee of $25 for a medical appointment and no-show fee of $50 for a cosmetic appointment if I do not contact the office at least 24 hours before my scheduled appointment time.

__If Esterson Dermatology is not directly contracted with your insurance company, our providers are considered out-of network providers and medical services will not be discounted. The penalties for seeing an out-of network provider may include 1) a larger deductible than usual, 2) a larger out of pocket expense for the patient or3) no benefits at all. As a courtesy, we will bill your insurance company for you. Any amount that is excluded, denied or not covered by your insurance company will be your responsibility to pay.

__Treatment of skin tags, aging spots and milia extractions considered elective (not medically necessary) and not covered by your insurance company will be billed the following: up to 10 lesions will be $100 charge and 10-20 lesions will be assessed $200 charge.

__I authorize and request that my insurance company, in lieu of reimbursing me directly, pay the doctor or medical group any benefit for services rendered.

__ I understand that medical insurance carrier may pay less than the actual bill for services. I agree that I may be responsible for payment of all services rendered on my behalf or my dependents that are above reasonable and customary of my medical insurance coverage's.

__I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have contract lab or facility, or if services are not covered by my insurance.

Our staff is dedicated to working with you and your insurance carrier to obtain the proper reimbursement for your medical services. However, as a patient you have a responsibility regarding their coverage as well. We appreciate your assistance in working with our staff.

Signature:_____ Date:_____