FINANCIAL POLICY AND SIGNATURE ON FILE

I authorize the release of any medical pertinent information to my consulting provider, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to Biltmore Dermatology Associates, PA.

I understand that I am financially responsible for all services rendered including for the following reasons:

1) No proper referral at the time of service or referral is invalid/expired.
2) Incorrect/Invalid insurance information given or failure to give any or new updated insurance information.
3) Expenses not covered by insurance including labs.
4) Deductible not met.
5) Services rendered deemed medically unnecessary by insurance or non-covered/excluded services by your plan.
6) Not in network with your plan.

Failure of insurance company to pay does not excuse patient's financial responsibility. It is patient's responsibility to know what is and is not covered by their insurance policy/plan (including Medicare beneficiaries). Your contract is between you and your insurance carrier. YOU ARE RESPONSIBLE FOR VERIFYING NETWORK STATUS DIRECTLY WITH YOUR INSURANCE CARRIER.

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. You may be balance billed per your insurance contract guidelines for any amount not collected or known at the time of service. Outstanding balances not addressed/paid in a timely fashion may be forwarded to collections reported to your credit.

Returned Checks: In the event a check is returned for Non-Sufficient Funds, we will assess a $25.00 charge in addition to your current balance to cover bank charges incurred by our office due to Non-Sufficient Funds.

Prescriptions: Please bring a list of your current medications with you at the time of your appointment. Also, please allow at least 1 business day for refill requests to be filled.

Missed Appointments: We charge $50.00 for any no show appointment not cancelled within 24 hrs. This charge will be billed directly to you. Please help us to serve you better by keeping all scheduled appointments. If you "no show" to 3 appointments within 1 year, we have the right to dismiss you from our practice for non-compliance.

Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Patient/Guardian Signature for Financial and Office Policies
(Refusal to sign does NOT prevent responsibility/obligation regarding this office's financial policy).

X_____**Date**_____