OFFICE & FINANCIAL POLICIES

Welcome and thank you for choosing **Houston Dermatology Associates, P.A.** for your dermatology care. We look forward to serving your dermatological needs and strive to provide you with the best quality of care. Please carefully review the following valuable information as it is intended to serve as your guide to a smooth and productive visit.

Initial ____ **Insurance:** When making an appointment with one of our physicians, it is your responsibility to confirm with your insurance company that the physician is currently under contract with your plan. If your plan requires a referral and you or your provider does not provide one by your scheduled appointment time, please be prepared to pay for your visit in full or reschedule.

Initial ____ **Late arrivals**: We do our best to keep to the schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 30 minutes past your scheduled appointment time, you may be rescheduled so that other patients are not inconvenienced.

Initial ____ **Check-In**: Your time is very important to you and to us. The first step in keeping your appointment on time is being prepared. This includes filling out all required paperwork prior to your first appointment. It is extremely important that you provide each piece of information that is requested on both the Patient Information and Medical History Forms. This will avoid delays in creating your chart and account at your visit. Please arrive at least 15 minutes prior to your scheduled time so that all paperwork may be completed BEFORE you are scheduled to see the physician. Although we verify your benefits before your initial appointment, you must present your current insurance card along with a valid picture I.D. in order to verify your identity. This will insure that all information is entered accurately and will prevent errors in filing your claims. Without the insurance card, we will be unable to file your insurance and you will be responsible for the day's charges. On EACH follow-up visit you will be asked to verify demographic and insurance information so that our records remain up-to-date.

Initial ____ **Check-Out**: Please note that payment for all co-pays and/or deductibles is due at the time of service. Typically, only an Office Visit charge is covered by your co-pay and any additional services or treatment are subject to your plan's specific details. ***The patient is responsible for knowing their insurance benefit coverage and whether a referral is needed for the specialist visits***. It is strongly recommended that you contact your insurance company prior to your visit to get an understanding of your benefits.

Initial ____ **Non-covered services**: An "Insurance Waiver" may be required to acknowledge understanding of your responsibility for paying for non-covered services. In dermatology, there are many procedures that are considered by Medicare and private insurers as non-covered, including elective removal of skin tags and seborrheic keratosis, cosmetic treatment of facial spider veins, removal of whiteheads, as well as others. If your visit is for a non-covered service, please be prepared to pay for the visit in full. Cosmetic procedures including, but not limited to chemical peels, Botox, Juvederm, and Restylane injections are not covered by insurance and claims will not be filed for them.

Initial ____ **No Shows and late cancellations**: We require a 24-hour advance notice if you must cancel your appointment. For your convenience, we offer appointment reminder calls 48 hours prior to your appointment which will allow you to cancel or reschedule at that time. If you cancel on the same day as your appointment a $35 fee may be assessed to your account. Surgery/cosmetic patients who fail to contact us or no-show may have a $100.00 fee assessed to your account.

Initial ____ **Minors**: The parent(s) or guardian(s) of minor patients MUST accompany the child for the initial evaluation. It is the responsibility of the parent or guardian to provide current insurance information and payment in full for services provided thereafter, should the child be unaccompanied at future visits.

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing by signing this statement.

Patient Name: ____ DOB: ____________________

Responsible Person's Signature: _______________________________________Date: ____________________