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251.378.0200

Financial Policy

This financial policy contains important information about billing and payment for our professional services. It is intended to help us provide the best possible medical care while also controlling administrative costs. It outlines our responsibilities, and those of our patients, with regard to billing and payment for our services.

Our practice participates with many health insurance companies and managed care programs. Our billing office will submit a claim for any services rendered to a patient who is a member of one of these plans. Patients must provide all necessary insurance information and complete any forms before leaving the office.

If a patient is a member of an insurance plan with which we do not participate, our office will no longer file the claim on the patient's behalf. The patient will be responsible for filing the claim and any remaining balance not covered by the carrier.

It is the patient's responsibility to make payment at the time of service for any co-payments or co-insurance due. Any services not covered by a patient's insurance plan are the patient's responsibility and payment in full is expected at the time of service. Payment for professional services can be made by cash, check, credit card or debit card. There will be a $30 charge for each returned check.

It is the patient's responsibility to ensure that any required referral for treatment is provided prior to the visit. If a referral is not obtained the visit may be rescheduled or the patient will be personally responsible for payment of services rendered.

It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit. If the patient does not have insurance coverage or their coverage will not cover the services being performed, payment in full is expected at the time of service.

Our staff is happy to help with insurance questions relating to a claim that has been filed, or to provide additional information required by the insurance carrier to process the claim. However, patients should direct questions about coverage for specific procedures to a representative of their insurance company's member services department. The phone number for member services is usually on the insurance card.

An adult accompanying a child under 18 and/or the parent or guardian of the child is responsible for payment according to the terms described above. Non-emergency treatment for unaccompanied children may be rescheduled unless charges and/or co-pays are made at the time of service.

Each time a payment is made by your insurance carrier you will receive an EOB (Explanation of Benefits) from your insurance carrier. The EOB explains how the insurance carrier paid the claim, as well as, the patient responsibility portion.

You, the patient, have a contract with your insurance carrier. It is important to note that the physician also has a contract with the carrier. It is part of your contract to pay all co-pays, co-insurance and deductibles. It is part of the physician's contract that we will diligently collect co-pays, co-insurance and deductibles. Repeated failure to pay the patient portion of a visit will be reported to your insurance carrier.

Telephone Consumer Protection Act (TCPA) Disclosure: Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay reasonable attorney fees and collection expense. All delinquent accounts bear interest at the legal rate. I agree, in order for the practice to service my account or to collect monies I may owe, **Kathryn Dempsey Dermatology, P.C.**, and or agents may contact me by telephone at any telephone number associated to my account, including wireless telephone numbers, which could result in charges to me. You may also contact me by text messages and by email using the email address I provided. I understand methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, if applicable.

I have read this disclosure and agree that the practice's employees and/or agents, may contact me/us as described above.

I have read and understand the financial policy as stated.

_____ _____

Patient **Date**

_____ _____

Witness **Date**