RADIANT
DERMATOLOGY & AESTHETICS

Office and Financial Policies

Welcome and thank you for choosing Radiant Dermatology & Aesthetics for your medical care. We are committed to providing you with the highest quality medical care in an efficient and cost-effective manner. We hope that by providing you with our policies in advance we can prevent any misunderstanding or frustration at the time of your visit.

Initials:_____ **Insurance**: The patient is responsible for knowing their insurance benefits including their deductible and out- of-pocket expense. Copay, Deductibles and patient's financial portion including any balance will be collected at the time of service. You may be asked to reschedule your appointment for non-payment. We will gladly file your insurance claim on your behalf. We will not be involved in disputes between you and your insurance company regarding coverage and/or policy benefits. You are responsible for the timely payment on your account.

Initials:_____ **Cancellations:** Please call our office 24 hours in advance if you are unable to keep a scheduled appointment. If you do cancel within 24 hours, you may be charged a No Show Fee of $50.

Initials:_____ **Referrals:** Patients with an **HMO** policy need referrals to see any specialist. You may be required to go back to your primary care physician to obtain a referral for a specialist that we want you to see. This is an HMO guideline that we have no control of.

Initials:_____ **Patient Balances:** Please be prepared to pay the current visits as well as any past balances on your account. Copay, Deductible, Out-of-pocket expense and non-covered services will required at the time of service. For your convenience we take cash, check and credit cards.

Initials:_____ **Late Arrivals:** We do our best to have less patient wait time but when a patient arrives late, it is impossible to stay on schedule. If you arrive 15 minutes late you may be asked to reschedule your appointment to keep our schedule on time.

Initials:_____ **Dishonored Checks:** A $30 Return Check Fee will be assessed on all dishonored checks. If you have 2 dishonored checks on file, check payment will no longer be a payment option for you but will gladly accept cash or credit card payments on your future visits.

Initials:_____ **Collections:** You will be receiving at least 3 statements from our office for balances owed. Please ensure to make payment arrangements, if necessary, to keep your account current. If your address changes it is your responsibility to inform our office to update our records. Otherwise, your account will be turned over to collections when it is returned as a bad address. When your account is already in collections, you **may not** be seen until the account is paid in full at the collection agency.

Initials:_____ **Prescriptions:** It is the patient's responsibility to call the pharmacy 5 days prior to running out of medication. **Refills may take 2 – 4 business days to be refilled.**

I have read understand and agree to the above office and Financial/Office policies. I hereby attest that I have given and agree to provide current demographics and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.

Patient name:_____ DOB: _____

Signature:_____ Date:_____