CHAPEL HILL
DERMATOLOGY

Patient Financial Policy

Thank you for choosing our practice! Chapel Hill Dermatology, P.A. is committed to providing the best patient care possible. We strive to be attentive and responsive to our patients' needs. We believe that establishing a written financial policy is mutually beneficial for all parties. Our goal is to avoid any miscommunication or concerns regarding financial matters.

We participate with most insurance plans. Each plan has different benefits, as well as different financial obligations. Not all insurance policies cover all services. It is impossible for us to know the unique benefits of your policy, so it remains **your** responsibility to check with your insurance company to determine covered benefits and what your possible financial obligations might be.

-Please bring your most recent insurance card with you to each visit.

-Payment of your co-pay is expected at the time of service. Self-pay patients without insurance and patients requesting elective cosmetic procedures are also expected to pay in full on the day of their office visit.

-We are required by contractual obligation with medical insurance companies to **collect your co-pay for each and every visit.**

-You may be charged a **$50 no-show fee** for any missed appointments if you do not give us 24 hours' notice.

-Any old balances on your account must be paid in full prior to receiving additional services.

-A service charge of $35 will be added to accounts for **returned** checks.

-Past-due accounts more than **120 days** old may be turned over to a collection agency. I understand that I will be legally responsible for all costs incurred with the collection of my account, including court costs, reasonable attorney fees, and other potential necessary expenses if I default on any unpaid balance.

We appreciate the opportunity to participate in your healthcare. If you have any questions regarding this policy, please let us know.

I have read, understand, and agree to the above financial policies. I understand that any charges not covered by my insurance company, including co-pays, deductibles and co-insurance, are my responsibility.

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Signature Date