Patient Financial Policy Agreement

We are committed to providing you with quality healthcare and would appreciate your commitment to adhere to this Financial Policy Agreement. Please read this policy carefully and sign the Acknowledgement section at the bottom of this form. Please do not hesitate to ask a member of our staff if you have any questions.

For Medicare Recipients ONLY

Name of Beneficiary: _____ Date: _____

I request payment of authorized Medicare benefits be made directly to Dr. Valerie G. Davis of Davis Dermatology for any services provided to me. I authorize the release of information to Medicare and my secondary insurance to assist me in the processing and payment of all claims. Dr. Valerie Davis agrees to accept Medicare assignment and I will be responsible for any deductible, coinsurance or any non-covered services determined by Medicare.

FOR ALL PATIENTS Insurance and Payment

1. All patients are required to provide a valid, current proof of insurance and a copy of your driver's license. Failure to do so might result in denial of payment from your insurance plan and the balance will be your responsibility.

2. **Payment of all deductibles, copays, coinsurances and other patient financial responsibilities are required at each office visit *unless* payment arrangements have been made in advance. *Your health policy is a contract between you and your insurance company and we are NOT a party to that contract.***

3. We will submit your claim and assist you in any reasonable way to help get your claim paid. It is your responsibility to provide your insurance company with any requested information in a timely manner. **You are responsible for services that are NOT COVERED by your plan.**

4. If we do **NOT** participate with your insurance plan, we will submit a claim to your insurance carrier as a courtesy to you but ***PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDEREED*.**

5. **Self-Payment:** Payment is expected at the time services are rendered unless prior arrangements have been made.

6. **Medicaid:** (if applicable) it is the patients responsibility that all proper authorizations have been obtained from your Medipass provider, otherwise payment is expected at the time services are rendered.

7. **Care for minors:** A parent or legal guardian **MUST** accompany minor patients on the patient's first visit. The accompanying adult is responsible for payment of the account, according to the policy outlined above.

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Please Complete Other Side

Note: This policy applies only to Davis Dermatology

- **All lesions removed will be sent to a pathology lab.**
- **Payment for all non-medically necessary cosmetic services is expected at the time of the visit and will not be submitted to your insurance.**

By signing below, I acknowledge that I have read, understand and agree to the above Patient Financial Policy Agreement.

I authorize my insurance benefits to be paid directly to Dr. Valerie G. Davis and I also authorize the release of my medical information to my insurance company when required to facilitate payment of a claim.

_____ _____

Patient/Legal Guardian Signature Date

_____

Printed Name