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Dr. Dean Burget, MD
Dr. Jason Hendrix, DO
Dr. Stephen Schleicher, MD
Amy Hendrix, CRNP
Jamie LaPorte, PA-C
Todd Staub, NP-C

PAYMENT POLICY

Thank you for choosing us as your skin care provider. We are committed to providing you with quality and affordable health care. We understand you may have some questions regarding patient and insurance responsibility for services rendered and hope we can provide more understanding on this topic.

INSURANCE. We participate in most plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a plan we are contracted with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.

It is your responsibility to keep us updated with your correct insurance information. Upon arrival we ask that you come prepared to present your insurance card at every visit to verify that our office has the most updated card on file.

Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

CO-PAYMENTS AND DEDUCTIBLES. According to your insurance plan, you are responsible for any and all co-pays, deductibles, and coinsurances. All co-payments and deductibles must be paid for at the time of service. **______ Initials**

We accept checks, cash, Care credit and all major credit cards.

An additional $30.00 fee will be charged for any checks returned for insufficient funds or any other reason the check would be declined. Checks will no longer be permitted as a method of payment if there is a history of returned checks.

NON-COVERED SERVICES. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered medically necessary by your insurance company. You must pay for these services and any cosmetic procedures in full at the time of visit.

______ Initials

SELF-PAY patients are expected to pay for services in full at the time of visit. **______ Initials**

PROOF OF INSURANCE. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you

fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. ______ **Initials**

CLAIMS SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. The balance becomes your responsibility if no payment is received from the insurance company. ______ **Initials**

REFERRALS: It is your responsibility to obtain a referral from your PCP prior to your office visit, and notify a staff member if your insurance prefers a specific lab. ______ **Initials**

COVERAGE CHANGES. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. ______ **Initials**

APPOINTMENTS: All children under the age of 18 must be accompanied by an adult that has authority to make health care decisions and authority to sign necessary forms. If parent/guardian cannot be present an **Authorization to Treat Minor Patient in Absence of Parent/Guardian form** must be provided. You may print the form from our website by going to readingderm.com and selecting *Patient Forms* or you may send a note stating that Reading Dermatology may treat the patient as deems necessary and appropriate otherwise the visit will have to be rescheduled. ______ **Initials**

MISSED APPOINTMENTS. Our policy is to charge $50.00 for missed appointments not cancelled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. ______ **Initials**

FORMS. We may bill $20 for forms or letters that a provider completes on your behalf. ______ **Initials**

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for your understanding of our office policy. Please let us know if you have any questions or concerns.

I have read and understand the office policy and agree to abide by its guidelines:

Name of patient or responsible party: ____

Signature of patient or responsible party: ____

Date: _______________