Shenandoah Dermatology & Aesthetics

(Effective 11/29/2016)
SUMMARY OF FINANCIAL RESPONSIBILITY

Unless other arrangements are made, payment for visit is due at the time of the service (either full fee if you are paying privately, or your co-payment if we are billing your insurance company). Insurance is billed as a service to our patients. I understand that all charges not paid by my insurance carrier(s) remain my responsibility. Office staff is available to discuss potential payment issues with you.

Cancellation policy

Twenty-four hour notice is required for a cancellation of scheduled appointments. You may be subject to a charge of the following fees for appointments that you "no show": No show fee is $50.00.

You are at risk of losing your privilege to receive care at Shenandoah Dermatology if you "no show" for two consecutive appointments.

Please review the following:

- I understand the insurance may be filed for me, but I am ultimately responsible for payment of fees regardless of insurance coverage. I authorize the release of medical information required to process insurance claims and/or to complete Treatment Plans/Reviews as requested by insurance or managed care companies.
- I understand that Shenandoah Dermatology accepts payment by cash, check or credit card, including Care Credit.
- I authorize payment for my insurance company to be made directly to the practice.
- I understand that I am responsible for obtaining proper (pre)authorization from my insurance company if necessary. I accept responsibility for payment if authorization is not obtained.
- I understand that I may be billed for any missed appointments unless I cancel at least 24 hours before my scheduled appointment. Charges for "no shows" are NOT covered by the insurance company.
- I understand that mailed monthly bills are due at the time of receipt. Any bill not paid will be turned over to a collection agency, unless other arrangements have been made. If my account becomes assigned to a collection agency, I agree to pay all cost of collection, including $30 collection fee, court costs and attorney fees.
- I agree that, in order for Shenandoah Dermatology to service my account or to collect any amounts I may owe, Shenandoah Dermatology may contact me by telephone at any telephone number associated with my account. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, text or email, as applicable.
- Social security numbers are required for billing purposes in our office. I understand that if I choose not to disclose my social security number there will be a $75 charge due prior to treatment in the office. After insurance processing, I understand that I will be refunded any applicable credits.

HIPAA Policy

In addition to the above financial statement, I have reviewed a copy of the HIPAA privacy policy posted in the main office and can receive a copy at my request.

SSN: _____

Signature:_____ Date: _____

*If patient is a minor, parent/legal guardian must sign and we must have the guardian's SSN.

I hereby give my permission to disclose personal health information about my treatment to the following individuals: (Example: Spouse, parent/legal guardian, friend, etc.)

Name:_____ Phone#: _____ Relationship:_____

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