OFFICE COLLECTIONS ACKNOWLEDGMENT & AUTHORIZATION

Thank you for choosing Adult & Pediatric Dermatology for your healthcare needs. To help us fulfill our mission to provide personalized and exceptional care to each of our patients, we have developed office collections policies to create a productive relationship between you and our team of providers.

This form outlines our office procedures for patients with active, In-Network medical insurance coverage.

- As a courtesy before your appointment, we will complete an Insurance Verification based on the information you provided to our office.
- In accordance with our Office Policies, any co-payment, deductible, coinsurance, uninsured/self-payment and/or any non-covered service obligations are due at the time of services rendered.
- At your appointment, we will collect any applicable co-payment or deposit toward any applicable remaining deductible. Such deposit amount will be calculated as follows:
    - Excision: $400.00 deposit or up to remaining deductible, whichever is less
    - New Patient Office Visit: $75.00 deposit or up to remaining deductible, whichever is less.
    - Established Patient Office Visit: $50.00 deposit or up to remaining deductible, whichever is less.
- Your Insurance carrier will process the claim, pay their portion and transfer any applicable balance to your responsibility per your benefit coverage.
- Our office then will apply any applicable co-payment and/or deposit toward your patient responsibility. If you have an outstanding balance, you will receive a statement and be obligated to remit payment. If you have a credit on your account, you will receive an account credit or refund for any overages paid.
- You may pay your outstanding balance with your preferred method of payment within 25 days of your initial statement. If you do not pay your balance in full within 25 days, then, pursuant to the credit card authorization below, we will automatically process your outstanding balance and send a receipt to the email on file.

My signature below indicates that I have read, understand and will comply with the information contained in this Office Collections Acknowledgment & Authorization.

_____

Signature of Patient (or Legal Representative)

_____

Print Name of Patient

I hereby authorize Adult & Pediatric Dermatology to charge outstanding account balances to the card that is securely stored on file.

Visa Mastercard American Express Other:_____

Account Number(Last 4 digits only*)_____ Expiration Date_____ CVS Code_____

Signature_____ Date_____

*The authorized card will be swiped, read, or entered directly into our secure credit card processing system.