EMERALD COAST
DERMATOLOGY

Financial Policy

Thank you for choosing Emerald Coast Dermatology & Skin Surgery Center. Our Financial policies are listed below for your careful review. These policies are intended to make your office visit as pleasant as possible, and enable our Medical Staff provide the highest quality of care that you are accustom to.

Please read all information and acknowledge by signing below.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address or telephone number(s), please notify our office immediately.
3. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder.
4. We will collect your deductible, co-payment, or charge for a non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, and all major credit cards.
5. If we do not participate with your insurance company, you will be expected to make payment in full at the time service is rendered.
6. If your insurance denies our charges, or does not pay us in a timely manner, or if your account becomes delinquent we reserve the right to refer your account to a collection agency and to be reported to the credit bureau.
7. No show or missed appointments – We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel an appointment by you. If **two** appointments are missed without cancellation, you will be charged a $25.00 fee. If **three** appointments are missed, you will be dismissed from the practice for non-compliance.

Please remember, whether you have insurance or not, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our office.

Thank you very much for reading and adhering to our policies.

I have read and have a full understanding of the financial policy of Emerald Coast Dermatology.

Signature: _____ Date: _____

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HIPPA CONSENT FORM

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) this practice may use your personal health information for the purposes of treatment, payment, or healthcare operations only. The specific uses and disclosures that we intend to make are described in our Privacy Policy. You have the right to review our Privacy Policy prior to signing this consent form. You may request restrictions on the uses and disclosures described in the privacy policy by describing the requested restrictions in the "Restriction Request" section of this form.

CONSENT SECTION

I, _____, hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations. My signature below indicates that I have been given the opportunity to review the Privacy Policy of Emerald Coast Dermatology & Skin Surgery Center, P.A.

Please allow the following person(s) to obtain my personal healthcare information. (If none, write NONE)

_____ _____

_____ _____

RESTRICTION REQUEST SECTION

I hereby request the following **restrictions** on the use and disclosure of my health information. (Please describe in detail)

_____

_____

_____ _____

Signature **Date**