DermPartners

21020 State Rd 7 Suite 120

Boca Raton FL 33428

Shari Topper MD   Jodi Fiedler MD   Ashley Hynes PA-C

Office Financial and Administrative Policy

Name: (Please Print) ____

Address:____

EMAIL Address: (of parent or guardian if under 18) ______________________

We would like to share the following policies with you so that you understand your responsibility regarding charges for the services rendered in our office.

1. If we participate (are contracted) with an insurance plan under which you are covered, we will bill the carrier for all medical (non-cosmetic) charges. We will bill your primary and secondary insurances (if applicable). **You will be responsible at the time of service for payment of:**
   a. The annual deductible and co-insurance
   b. Co-payments
   c. Charges for non-covered or cosmetic services
2. We are participating providers with Medicare and will bill Medicare and any secondary plans. You will be responsible at the time of service for payment of:
   a. The annual deductible and co-insurance if not covered by your secondary plan
   b. Co-payments if applicable
   c. Charges for non-covered services or cosmetic services*

   *You will be asked to sign an ABN (advanced beneficiary notification) in the event a medical service is being done that we know is not covered by Medicare
3. If you are not covered by insurance or we do not participate in your insurance plan you will be charged according to our private pay rates. **All charges are payable in full at the time of service.**
4. A $25.00 fee will be assessed for any missed (no show) appointment. This fee must be paid before scheduling any future appointments.
5. By providing my email address I give you permission to send me appointment reminders, patient information, newsletters and promotional emails about specials and events. I understand that I may unsubscribe at any time, and that you will never sell or share my email with any external entity. *Check here if you do not want to receive newsletters or promotional emails.* [ ]

By signing this agreement I understand the financial policy of our office and your responsibilities regarding charges incurred. Furthermore my signature authorizes payment of medical benefits by the insurance company for myself or dependents to DermPartners. It further authorizes the release of any medical information to the insurance company they deem necessary to process the medical claim(s).

Signed:______________________________   Date: ____________________

(PARENT OR GUARDIAN IF UNDER 18 YEARS OF AGE)

MEDICARE PATIENTS PLEASE READ AND SIGN REVERSE

Medicare Patients Authorization:
I request the payment of authorized Medicare benefits be made to DermPartners on my behalf for all covered services. I authorize the release of any medical information deemed necessary by Medicare to them in order to determine the benefits available.

Signed: ___________________________________ Date: ______________________