TUCSON DERMATOLOGY, LTD.
FINANCIAL POLICY

Dear Patient:

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please ask our staff.

We ask that all patients read and sign our Financial Policy prior to seeing the doctor.

Payment for services are due at the time services are rendered, if we are not providers with your insurance company.

Please understand we cannot file your insurance unless we are providers with that company. We appreciate your cooperation.

In cases where we will accept assignment of insurance benefits, please understand the following:

1. Your insurance policy is a contract between you and your insurance company. Our relationship is with you, not with your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
3. **If the insurance company does not pay in full within 45 days, we require you to pay the balance due with cash, check, MasterCard, Visa, or Discover.**
4. Returned check are subject to a $10 fee.
5. In the event that it becomes necessary to purse collection efforts, or if there is any dispute between patient and doctor regarding charges rendered, the successful party, whether by compromise, settlement arbitration award of judgment, shall collect any and all costs incurred therein including attorney's; fees.
6. **Medicare patients – you are responsible for the 20% of Medicare's allowed amount and any unpaid deductible you may have at time of service.**
7. “I hereby authorized my insurance benefits to be paid to the physician, and I understand that I am financially responsible for any charges that are not paid for by the insurance company. I also authorize the physician to release any information required.”
8. Should you request a paper copy of your medical records, there will be a $25.00 fee.

Please call if you have to reschedule or cancel an appointment.

Patient's Signature or Guardian_____Date:_____

We understand that temporary financial hardships may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.