DERMATOLOGY CHICAGO FINANCIAL POLICY

Thank you for choosing Dermatology-Chicago S.C. for your skincare needs. We are committed to the successful treatment of your skin problems. Please understand that payment of your bill is your responsibility to our professional relationship. This form outlines our financial policy. If you have any questions please call our billing department at (312) 372-0150.

All patients must complete our patient registration and HIPPA forms.

If you do not have insurance or if you do not have proof of your insurance, full payment is expected at the time of service. We accept cash, check, Visa, MasterCard, Discover, and American express credit and debit cards.

If you have **PPO or indemnity insurance**, we are happy to bill your insurance company directly. Your Co-pay must be paid at the time of service. We accept cash, check, Visa, MasterCard, Discover, and American express credit and debit cards. **In addition**, we require a credit or debit card to be placed on hold. This card is securely encrypted by our credit card processor. **After** your insurance company processes the claim, any owed balance will be charged to this card. You will receive an email notification that the charge has be applied.

A **$35** cancellation fee may be charged for no shows or appointments not cancelled 24 hours in advance. A $75 fee will may be charged for surgical procedure no shows or appointments not cancelled 24 hours in advance.

A $25 charge will be assessed on all returned checks.

Medicare assignment is accepted. As a Medicare patient you are responsible for the difference between the approved charge and the amount Medicare pays as well as any deductible amount. If you have a supplemental insurance policy (we do not accept Illinois Public Aid) and provide us the necessary information, we will submit the claim for you.

HMO or point of service plan eligible patients must have all appropriate referral authorizations sent by their primary care physician's office and verified by our office before being seen. All co-payments must be paid at the time of service.

All cosmetic procedures must be paid in full at the time of service.

I authorize Dermatology-Chicago S.C. to bill my credit card for balances after the **insurance** company processes my claim or if the **insurance** company doesn't process the claim after 90 days.

Credit /debit **Cardholder** information: (name and address associated with the credit card)

Name of cardholder: _____

Cardholder's address: _____

City: _____State: _____Zip_____ Phone:_____

E-mail address to send receipt to: _____

Signature: _____Date: _____+