RD
REED DERMATOLOGY
NORTHWEST

OFFICE/FINANCIAL POLICY

We require patients to provide a copy of their insurance card, proof of identification and co-payment at check-in for every visit. If you do not have your insurance card, photo ID or co-payment with you at the time of your visit, your appointment may be rescheduled.

PATIENT RESPONSIBILITY
Patients are responsible for all charges resulting from treatment provided by Reed Dermatology. Payment is due in full within 30 days of receiving your first statement unless other financial arrangements have been made with the Billing Office. Please remember your insurance policy is an agreement between you and your insurance company, and it is ultimately your responsibility to pay for any balance not paid or covered by your insurance company. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

CO-PAYMENTS, DEDUCTIBLES AND CO-INSURANCE
Co-payments are the amounts your insurance policy requires us to collect with each visit and are due at the time of service. **Patients who arrive without their co-pay, may be rescheduled or will be charged a $20 fee (not billable to insurance).** The deductible is the total amount your policy **requires you to pay** before they will pay claims on your behalf. We may ask you to pay the estimated unmet portion of your deductible at time of service. The co-insurance is the percentage of the bill that is your financial responsibility according to the contract with your insurance company. We will collect $30 at time of visit to be applied towards your co-insurance.

INSURANCE BILLING
As a courtesy, we will bill your primary and secondary insurances for you. However, primary responsibility for the account is yours. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your new card at your visit. If you do not have your insurance card with you at the time of your visit to provide us with valid insurance information, you may need to pay up front for your visit for the services provided, or your appointment rescheduled. We do not file tertiary claims but will be happy to provide any documentation that will assist you**. If you provide us with incorrect information, it will then be your responsibility to pay your balance in full and for you to bill your insurance company for reimbursement**.

LATE ARRIVAL/APPOINTMENT NO-SHOW
A patient who arrives any time after his/her appointment time is considered a late arrival. A late arrival will be checked in and worked into the schedule if time allows and with the doctor’s approval. If the patient is more than 10 minutes late, the patient will be considered a no-show and the appointment will need to be rescheduled. Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 hours prior to the scheduled time is considered a no-show. A no-show patient may be charged $40 for failure to show. A patient who fails to present themselves two times for scheduled appointments may be dismissed from the practice at the doctor’s discretion.

RETURNED CHECKS
Returned checks will incur a $30 service charge. You will be asked to bring cash, certified funds, credit/debit card or a money order to cover the amount of the check plus the $30 service charge. All outstanding charges must be paid prior to receiving future services.

PAST DUE AND COLLECTION ACCOUNTS
We reserve the right to send accounts with balances that have been outstanding over 90 days from the date of service or the date of payment received from your insurance company, whichever is more, to a collection agency. Please be aware that if a balance remains unpaid, you and/or your immediate family members may be discharged from this practice.

NO ELECTRONIC RECORDING DEVICES
To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited at any location within the office.

The patient’s signature (or the signature of the patient’s parent or legal guardian) acknowledges that you understand and accept the above information. **I have read the above and agree with the terms of this agreement.**

Print Name ____ Date ____________________

Signature ____

V5.22.19