Tina Snodgrass Skin Care Practice, PLLC

Office Guidelines and Procedures

Office Hours

The office is open from 9:00am to 5:00pm on Monday and Thursday for medical dermatology patients. We schedule cosmetic dermatology patients on Tuesday and Friday by appointment only. Our confidential voicemail is available at all times when we are unable to answer the phone or out of the office.

Appointments

Our patients are seen by appointment only. If you arrive late for your appointment, it may be necessary to reschedule as we want to ensure all patients get the necessary time they require.

No Show Appointments

We provide services by appointment only, therefore it is necessary for you to provide 24 hour notice if you must cancel an appointment**. PLEASE NOTE**: You will be billed $25.00 for all missed appointments that were not cancelled within 24 hours. If possible, patients are given a courtesy call to remind them of their scheduled appointment. After 3 no call no shows you may be discharged from our practice.

Billing

We submit your services to your primary insurance company for you **one time**. If you have a secondary insurance, we will include that carrier in the filing. **YOU ALONE are responsible for your bill**. All copays and deductibles are due at the time of service. Any deductible or co-insurance amounts due at the time of service that are not collected will be billed to you once your insurance has been billed. Your account balance must be paid in full in accordance with the due date on your statement. There will be a 5% late fee added monthly for outstanding balances greater than 60 days. Late accounts must be paid in full before Ms. Snodgrass will see you again. If needed we do offer a self-pay payment plan; however, arrangements must be made in advance, and you must pay in full at time of service.

Email statements will be sent at the first of the month. If paper statements are requested, there will be a **$2.00 service fee per paper statement**s.

My email address is: _____

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the policies. I agree and accept to receiving billing statement via email. You may receive a copy of this document upon request.

Patient/Guardian Signature_____Date_____

Relationship to patient (if applicable) _____