

Colorado Springs Dermatology Clinic, P.C.

Financial Policy and Authorization

Patient Name: _____ **DOB:** _____

Thank you for choosing Colorado Springs Dermatology Clinic. Our physicians and staff are committed to providing you with the best medical care. Please read this form carefully, as it outlines our policy regarding payment and authorization to file your medical insurance claim.

All patients should provide accurate and complete personal and insurance information prior to your appointment. It is the patient's responsibility to make sure that we have your most recent information. If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered. All applicable co-pays and any prior balances are due at the time of service.

Colorado Springs Dermatology Clinic has preferred provider contracts with most insurance companies. Your insurance coverage is a contract between you and your insurance company. Colorado Springs Dermatology Clinic is not responsible for services denied by your insurance company. It is to our advantage, as well as your responsibility, to know and understand your medical insurance coverage. It is also your responsibility to know if your insurance company requires a referral prior to your appointment.

Financial Authorization: I hereby authorize my physician to bill my insurance company for services rendered. I also assign my physician any insurance payments for services provided to me. If these benefits are not paid to my physician, I agree to forward all health insurance payments I receive for services rendered to me immediately upon receipt. I am responsible for the payment of all charges for services rendered to the above patient. Payment will be made promptly, as bills are presented, with settlement in full or appropriate arrangements for settlement made.

The undersigned certifies that he/she read this document and that he/she is the patient or duly authorized as the patient's general agent to execute these consents and agreements and accepts these terms.

Payments: We accept cash, checks, Visa, MasterCard, Discover, American Express and upon approval Care Credit. Upon receipt of billing statements, outstanding balances are due within 30 days. Should your account become past due, it may be sent to a collection agency.

Missed Appointments: There is a \$90 charge for missed surgical appointments to the Mohs Surgery Center. If you must cancel an appointment, please call, and let us know at least 24 hours prior to your appointment. After three no show occurrences, the practice may elect to terminate our relationship with you.

By signing below, you acknowledge you have carefully read, understand, and agree to the above terms.

Signed: _____ Date: _____

Colorado Springs Dermatology Clinic, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.