MAHONEY
DERMATOLOGY SPECIALISTS, P.A.

Financial Policy

WELCOME to Mahoney Dermatology Specialists! We are pleased that you have joined our practice. Please read and complete the following. Our focus is to provide you with the best medical experience possible.

Please carefully read each of the following statements before signing:

- I understand there is a **late cancellation fee** if I do not give at least ***24 hours notice prior*** to the scheduled appointment, the fees are as follows:
  - $100 for scheduled surgical appointments. **A deposit is required**.
  - $50 for scheduled office visits.

- I understand I will be charged a $50 service fee for any insufficient funds and all my future payments must be made via cash or credit card.
- I understand my account is subject to a 1.5% interest charge per month on any balance older than 30 days.
- I understand if my account is turned over to a collection agency, I will be responsible for any cost incurred in the collection of the balance, which will include a 35% fee of your outstanding balance and/or any other charges.

Commercial insurance patients: On your behalf we submit all claims to your insurance company. However, it is your responsibility to know what benefits you have contracted for with your insurance carriers. Please be advised that we do verify benefits on the day of appointment, and will give an estimate based on the information we are given at the time of inquiry:

- I understand I am responsible for paying my annual deductible, co-insurance, copayment, and charges for any non-covered, cosmetic services at time of service with my credit card on file.
- **I understand if my insurance policy requires that I obtain a referral and or authorization, it is my responsibility to contact my primary care physician prior to my appointment and have it faxed to the office.**
- I understand not all services are covered by insurance; it is my responsibility to be aware whether provided services are a covered benefit under my insurance policy.
- I understand it is my responsibility to notify Mahoney Dermatology Specialists, P.A. of any changes in my insurance so that my coverage can be verified prior to my appointment.

By signing below, I acknowledge that I have read and understand all the above statements.

Printed Patient Name: _____ Patient DOB: _____/_____/_____

Patient or Guardian Signature: _____ **Date:** _____/_____/_____

PLEASE SIGN SO WE MAY HAVE YOUR MEDICARE AUTHOIRZATION ON FILE:

I authorize any Medicare or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on the Medicare Card: _____DATE: _____

Emergency Contact Information

In case of Emergency, who should be notified? _____ Phone: _____
Relationship to patient: _____
Do you give our office permission to discuss your medical information with family members? YES /NO If yes, please provide their names and phone numbers below.
Name: _____Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____