

## FINANCIAL POLICIES SUPPLEMENT

### Personal Checks

The Practice accepts personal checks for co-payments and deductibles. In the event that a check 'bounces' (i.e., insufficient funds exist to cover the check), the Practice will apply a fee of \$25. By signing below, I acknowledge and agree to abide by this policy.

Patients are responsible for balances not covered by their insurance policy (e.g., co-payments and deductibles). The Practice will mail invoices for all balances due and prompt payment is requested. Failure to settle balances in a timely manner may result in retention of a collection agency. Failure to settle balances may also result in a report to credit bureaus (e.g., Equifax) and may affect your ability to obtain credit in the future. BY signing below, I acknowledge and agree to abide by this policy.

### Failure to Appear for an Appointment

All patients receive a courtesy reminder call for upcoming appointments. Failure to call to cancel an appointment beforehand or failure to appear for an appointment (no show) will result in a fee of \$35. A fee will not be levied as long as an appointment is canceled beforehand. By signing below, I acknowledge and agree to abide by this policy.

### Failure to Appear for a Surgical Appointment

All patients are advised when booking surgical procedures that one week's notice is required to cancel without penalty. Failure to call or appear will result in a fee of \$150. By signing below, I acknowledge and agree to abide by this policy.

### Laboratory Charges and Deductibles

During your visit, skin biopsies or cultures may be obtained and sent to an outside laboratory. The Practice is in no way responsible for co-payments or deductibles levied by outside laboratories. By signing below, I acknowledge that the Practice cannot be held liable for these charges.

**Payments to our office must be made in the form of Visa, MasterCard, Discover, check or money order.**

**This office does not accept cash or AMEX. We apologize for any inconvenience.**

\_\_\_\_\_  
Last name, First name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date