



8300 Health Park – Suite 207 – Raleigh – NC – 27615
Phone (919) 573-9030 Fax (919) 573-9029

Financial Policy

GENERAL

We make every effort to see patients at their appointment time, **we do not overbook** to accommodate patients who do not keep their appointments. Therefore the practice charges \$75.00 for missed appointments not cancelled with at least one business day's notice.

MEDICAL

This office has contracts with Medicare and with many managed care and insurance plans. Our reception staff can assist you in determining whether your plan is one of these. However, it is your responsibility to be familiar with the particulars of your plan such as whether we would be considered in-network or out-of-network, etc.

If we have a contract with your plan, we will file a claim with your insurance company. Payment for the amount for which you are responsible (any deductibles, copays, percentages or non-covered services) is required at the time of service. If you do not have one of the plans with which the practice is contracted, the total cost of your visit is required at the time of service.

If at any time you are concerned about the cost of a procedure proposed by the doctor, you may ask for someone from the business office who will be happy to discuss the cost with you.

For your convenience in paying, this office accepts Master Card and Visa in addition to cash and personal checks. If your check is dishonored or returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of \$25.

Our fee for release of your medical records is \$15.00 per request.

COSMETIC

Cosmetic services (Laser surgery, Botox, fillers, dermabrasion, chemical peels etc) are offered by appointment only and a credit card number will be required to hold your appointment. A cancellation fee of 50% of the procedure cost will be charged for missed appointments that are not rescheduled within two business days notice.

I certify that I have read the financial policy of the Dermatology Center of Raleigh PA. and agree to abide by the policy.

Signature: _____ **Date:** _____

Credit Card Authorization

In the event that there are charges incurred as a result of your medical, surgical, or cosmetic visit with us, including charges generated by your insurance carrier that are your responsibility, The Dermatology Center of Raleigh reserves the right to bill these charges to your credit card on file with us.

_____ I understand that the amount charged to my credit card will be reflected on my credit card
(Initial) statement within seven days that the charge is made. The amount charged is based on services and/or products rendered. As a courtesy we will mail you a statement of these charges and the receipt of the charges made

Name of Card Holder: _____

Credit Card Number: _____

3 Digit Security Code (on back of card): _____

Expiration Date: _____

Billing Address for the Card: _____
