WASHINGTON DC DERMATOLOGY

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1140 Connecticut Ave. NW, Suite 675, Washington DC 20036
(One block from Farragut North, Two blocks from Farragut West Metro)

Financial Policy Agreement
Waiver for payment of services

Your insurance company may deny any procedure and/or visit. If my insurance company does not pay for these services, I agree to pay in full what my insurance deems my responsibility. Washington DC Dermatology has no input into the insurance companies classification of procedures.

I understand my insurance policy and my benefits ,I am aware that copayment for each office visit is due at the time of my visit. I also understand this office may bill me for my deductible, coinsurance and/or any other out-of-pocket charges as per my insurance plan. Insurance companies classify some dermatological procedures as cosmetic, your provider will let you know before any treatment or procedure is performed.

It is also my responsibility to keep referrals up to date if required by my insurance provider.
_____ (Initials)

Collections and Outstanding Balances

Washington DC Dermatology reserves the right to add a $35 monthly statement processing fee on any account that has an unpaid balance.

Any outstanding balance after 90 days of the date of service may be referred to an outside collection agency. Accounts referred to an outside collection agency or attorney may be subject to a collection fee of 25%, which will be added to the account at the time of write off.

Patients with unpaid delinquent accounts or accounts which have been sent to collections may be discharged from the practice.

I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. I understand that the terms of this financial agreement may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment for all services rendered to the patient herein.

By signing below, I have read and fully understand the contents of this financial policy.

Signature _____ Date _____

Print _____