



Mooreville Dermatology Center

Financial Policies & Authorizations

We are committed to providing you with the best possible care. If you have insurance, we are here to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our financial policy. If you have questions about the information below, please ask us, we are here to help.

Payment is required for all services at the time they are rendered unless you are enrolled in an insurance plan in which we participate. Any applicable co-payments, co-insurances and/or deductibles will be collected at the time of service. We accept payment in the form of cash, check, or credit card. Your insurance plan will be billed for the charges incurred. Please note that the patient is responsible for any/all charges not paid for by the insurance company. Prior authorization does not guarantee payment of claims.

Insurers will not pay for a list of services that they have deemed medically unnecessary. For those services, Mooreville Dermatology Center will have you sign a waiver acknowledging that you have been informed your insurance may not pay, and that you will be solely responsible for payment of that service. Payment is expected at the time of service for these non-covered services.

Lab and pathology fees are not part of the physician's fees. If a diagnostic procedure is performed, it is the patient's financial responsibility to pay any balance due to any outside facility that may be utilized to complete and determine the diagnosis for such procedure. Your signature below signifies your understanding and willingness to comply with these policies.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in management of your account.

The patient understands that delinquent accounts are subject to finance charges and collection fees.

PATIENT AGREEMENT: I have read and understand the financial policy above and agree to the terms stated.

Patient's/Guardian Signature _____ Date _____