mid-atlantic skin surgery institute

Verghese & Ling, MD PA

MEDICAL SKIN CARE | COSMETIC PROCEDURES | SKIN CANCER TREATMENTS

FINANCIAL POLICIES

It is the policy of Mid-Atlantic Skin to provide all patients with a copy of the Practice's financial policy that clearly outlines patients and practice financial responsibilities. This financial policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for services.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we are contracted or have out of network benefits, payment in full is required at each visit.

Some insurance companies will require referrals or pre-authorization. We will gladly assist you in meeting these requirements when requested, however, the responsibility is yours to ensure that any such requirements are complete prior to treatment. If it is required, and not completed, you may need to reschedule your appointment.

You will need to pay your portion of the visit within 90 days once your insurance company pays their portion. After 90 days and once your insurance company pays their portion, and if you have a remaining patient balance, 5% interest will be charged.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. **A $20 processing fee will be added to your account for all co-pays not paid at the time of service.**

3. Noncovered services. Please understand that some, and perhaps all, of the services you receive may not be covered by my insurance or not considered reasonable or necessary. Cosmetic procedures are not covered by insurance.

4. Updates. Our staff will ask you for ID to verify your billing information at each and every visit. Current information is essential in order for us to contact you regarding your treatment and for obtaining timely payment from your insurance company.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply in a timely manner with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim.

CareCredit®

Financing Available. Let us know if you are interested.

St. Patrick's Centre 173 St. Patrick's Drive Suite 201 | Waldorf, MD 20603 | 301-396-3401
Shanti Medical Center 26840 Point Lookout Road | Leonardtown, MD 20650 | 301-475-8091
Wildewood 23415 Three Notch Road Suite 2052 | California, MD 20619 | 240-237-8268

Info@MidAtlanticSkin.com

6. Coverage changes. If your insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits.

7. Patient who are minors. For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

8. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise pre-arranged. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this practice. If this occurs, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will be able to treat you on an emergency basis only. A $25.00 processing fee will be added to your account if it becomes necessary for Mid-Atlantic to refer your unpaid balance to an outside collection agency.

9. Missed appointments. You may be charged $50.00 fee for a missed appointment if you do not notify us at least 24 hours prior to your scheduled appointment time. Help us to serve you better by keeping your regularly scheduled appointment.

10. Payment Options. Payment for services can be made with cash, check, credit or debit card. Financing option through Care Credit-a wellness and beauty credit card- is available for patients that are cardholders or are interested in applying to be one. Our staff will be happy to assist you with the application process and, if approved, the fund could be available to you immediately after.

You will be charged a $30.00 processing fee for any personal check returned for nonpayment.

By signing this form, you authorize MidAtlantic Skin to release the necessary information in order to complete and process your insurance claims.

I have read and understand the payment policy and agree to abide by its guidelines:

Patient Name (Print): _____

_____ _____

Signature of Patient or Responsible Party if a Minor Date

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CREDIT CARD ON FILE POLICY

At MidAtlantic Skin, we require signed authorization for keeping your credit or debit card on file as a convenient method of payment for the services or portion of the services, that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of **$25** will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of **5%** of the total bill will be charged for each month that the bill remains unpaid.
Your credit card information is kept confidential and secured, and payments to your card are processed only under and after your authorization; payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account as applicable.

I authorize MidAtlantic Skin to charge the portion or total amount of my bill that is my financial responsibility to the following credit card on file.

I, _____, the undersigned, authorize and request MidAtlantic Skin to charge my credit card for balances due for services rendered that have been identified as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by MidAtlantic Skin.
This authorization will remain in effect until I, _____ cancel this authorization. To cancel, I, _____, must give notification to MidAtlantic Skin in writing and the account must be in good standing.

Card to be used (Last four #'s): _____

Patient Name (Print): _____

Patient Signature: _____ Date: ____ / ____ / ____

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I authorize MidAtlantic Skin to charge the portion or total amount of my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Visa ☐ MasterCard ☐ Discover ☐ Care Credit

Credit Card Number _____

CVV Code _____

Expiration Date ____ / ____ / ____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

Patient Name (Print): _____

Signature: _____ Date: ____ / ____ / ____