Bloomfield Dermatology
Financial Agreement

Due to ongoing insurance policy changes, it is no longer an easy task to monitor each individual policy. Insurance companies offer many different types of health coverage. Most of the plans require the patient to pay a deductible, copay and/or coinsurance charges. The amount of your copay, coinsurance and deductible depends on your individual insurance policy. Ultimately, it is **YOUR responsibility to understand your individual coverage.** Therefore, we strongly encourage you to check with your insurance company prior to any office procedure.

Please be advised that all costs incurred during your office visit that are not paid by your insurance company will be your responsibility to pay.

Deductible

Most insurance plans require a patient to pay an annual deductible. The patient must pay their health care provider/s for services totaling the deductible amount *before* the insurance company will begin to pay. Your insurance company will not pay any charges until you have met your *current yearly deductible.*

Copay/Coinsurance

Many insurance plans require the patient to pay a percentage of their health care costs. This amount is your coinsurance and is payable to the health care provider. You may also have a set amount you pay at each visit; this amount is your copay. If a service is not covered by the insurance plan, by law, the patient is usually responsible for the full amount.

Please Note

The billing staff will charge you according to the information provided by your insurance company. When we receive payment, if your insurance company has determined you owe additional charges, *as required by law*, you will be billed. All outstanding balances must be paid *prior* to your next visit.

I agree to pay for all charges not covered by insurance; this includes copays, coinsurance and deductibles.

I have read and understand the above information and agree to pay Bloomfield Dermatology as stated above.

Patient Signature: _____ **Date:** _____
Parent/Guardian Signature: _____ **Date:** _____
Witnessed: _____ **Date:** _____