

Dermatology Center of Williamsburg
5335 Discovery Park Blvd, Suite A
Williamsburg, VA 23188
(757)-645-3787 Fax # (757)-645-3774
www.dermatologycenterofwilliamsburg.com or www.dcw1.com



OFFICE FINANCIAL POLICY

BASIC POLICY - Payment for service is due in full at the time service is provided in our office.

FOR PATIENT WITH INSURANCE - Co-Payments and Deductibles are due at the time of service. At this time we only participate in **MEDICARE PART A & B, SENTARA/OPTIMA INSURANCE**, and **ANTHEM BLUE CROSS/BLUE SHIELD PPO**. We will bill only primary insurance. We do not file secondary insurance.

MEDICARE PATIENTS - We will bill Medicare for you. For most secondary insurances, Medicare will forward claims if a crossover bridge has been assigned.

SURGERY FEES - All co-payments are due in full at the time of surgery. (Prior authorization may be required by your insurance carrier)

FULL BODY EXAM - Periodic preventive health checks may or may not be covered under your health insurance policy; however, they may be recommended by your physician.

MISSED APPOINTMENTS - If your appointment is cancelled without a 24 hour notice or if you "No Show" twice, you will be charge a \$25.00 fee. I will also ask that you find another Dermatologist who can better service your needs.

PAYMENTS ON ACCOUNTS - **Accounts are given to the collection agency if your bill is not paid within 60 days.**

ASSIGNMENT OF INSURANCE BENEFITS - Patients please review:

I hereby assign all medical and/or surgical benefits-including major medical benefits to which I am entitled payable to the Dermatology Center of Williamsburg. This assignment will remain in effect until revoked by Dr. Corvette. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not covered by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I have read, understand and agree to the above financial policy for payment of professional fees. The patient is ultimately responsible for all professional fees. In the event that your account must be turned over to a collection agency, a 35% collection fee will be added to your account. There will be a \$25.00 fee for a check returned by the bank for any reason.

Your signature below signifies your understanding and willingness to comply with this policy.

Patient Name: _____

Signature of Patient/Responsible Party: _____ **Date:** _____