

Dermatology Center of Williamsburg
5335 Discovery Park Blvd., Suite A
Williamsburg, VA 23188



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dermatologycenterofwilliamsburg.com

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 participate with **MEDICARE PART B, SENTARA/OPTIMA, AETNA, CIGNA, FEDERAL and ANTHEM BLUE CROSS/BLUE SHIELD, and TRICARE STANDARD.** We will bill primary and secondary insurances.

MEDICARE PATIENTS

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

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 **48 hours notice** OR if you "no show" - **you will be charged a \$50.00 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. In the event that your account must be turned over to a collection agency, a 35% fee will be added to your account.

ASSIGNMENT OF INSURANCE BENEFITS

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.

****There will be a \$30.00 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 PRINTED NAME _____

RESPONSIBLE PARTY/PATIENT SIGNATURE _____ DATE _____