Financial Policy

Insurance:
As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefits of your medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you.

Financial Arrangements:
Because we realize that every person's financial situation is different, we provide a variety of payment options. For your convenience, we accept all major credit cards and checks. (returned checks will be subject to a $35 returned check fee). If the check is returned for any reason, you will have 7 days to contact our office and arrange another form of payment.

Appointments/Cancellations:
We gladly reserve appointment times for you as a courtesy; we will remind you of your appointment by calling and/or text/emailing you 7 and 4 days prior to your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patient's valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment. We reserve the right to charge $50 for regular appointments cancelled or broken without advance notice of 2 business days. We charge a $150 cancellation fee for regular surgery and $200 for Mohs surgery cancelled without providing us notice 3 business day prior to the appointment.

Patient/Parent/Guardian Responsibility:
I understand that whoever accompanies my child to their dermatology appointment has authorization to consent to medical care as needed, and is responsible for payment of medical services.
I acknowledge my responsibility for payment of all dermatology services provided by Miller Family Dermatology in accordance with the practice's fees and terms.
In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment.
At the initial visit you may sign our consent for minor treatment form that allows us to render care at follow up visits without the presence of a parent or guardian.

Late Fees:
I understand that my account becomes delinquent if not paid within 30 days after billing and the unpaid balance becomes subject to a monthly finance charge of 1.5% (18% APR) or $35, whichever is greater. Any further delinquency will warrant the balance and any administrative fees being assigned to a collection agency.

Assignment and Release:

I authorize payment to be made directly to Miller Family Dermatology by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

Patient/Parent/Guardian Signature:_____
Name Printed: _____
Relationship to patient: _____ Date: _____