

Patient Information and Agreement of Financial Responsibility

The purpose of this agreement is to help patients make a choice about whether or to they want to receive services, treatments or laboratory tests ordered by Kenner Dermatology Center knowing that they potentially will incur out of pocket expenses.

Insurance Claim Forms: As a courtesy, Kenner Dermatology Center will file your insurance claim for you. If your insurance rejects payment for any reason, you will be responsible for these charges. Certain procedures such as hair loss treatment, skin tag removal, mole biopsy, acne surgery or Blu U treatment may not be covered by your insurance plan and you would be responsible for the full charges. It is the patient's responsibility to provide our office with the current insurance information, subscriber number and insurance mailing address. Patients are responsible to follow up with any benefit questions with their insurance carrier. **KDC** is not responsible for any insurance benefit information. For all patients under a **HMO** plan, **IT IS YOUR RESPONSIBILITY TO HAVE A CURRENT REFERRAL FORM YOUR PRIMARY CARE PHYSICIAN AND /OR CURRENT AUTHORIZATION FROM YOUR INSURANCE COMPANY ON FILE WITH US BEFORE TIMEOF VISIT.** Our office is not responsible for unauthorized visits/treatments and you will be billed in full for these charges.

Collection Agency: If your account is over 90 days old with no payment activity, we will turn your account over to our collection agency; MEDCAH, P. O. Box 1187, Kailua, HI 96734 (808) 266-2020. To avoid collections, please be sure to pay at the time of the visit or mail in your payments by the due date.

Subscriber Payment or Co-Payment: Your payment portion is requested at the time of your visit if your insurance does not cover 100% of our charges. We accept cash, check, credit, and debit card. If you have no insurance coverage or a plan that we do not participate with, we will offer you a **DISCOUNT** only if you pay your estimated share in full at the time of the visit. There will be **NO DISCOUNT** if you wait until you are billed.

Bounced Checks: There will be an automatic service charge of \$25.00 for all returned checks imposed. **IN ADDITON TO THE AMOUNT OF THE RETURNED CHECK AND THE NSF FEE OF \$25.00, ANY OUTSTANDING PATIENT BALANCE MUST BE PAID PRIOR TO BEING SEEN FOR YOUR SCHEDULED APPOINTMENT.** Finally, at the discretion of the office, you may be put on a **CASH or CREDIT CARD ONLY** payment method for future appointments and/or services.

No Show and Cancellation Charges: As a courtesy to our physician, staff & other patients, we kindly ask that you cancel your appointment at least 24 hours in advance. There is a \$25.00 fee for not showing up for your appointment. True emergencies will be handled accordingly between patient and billing manager. For cancellations of cosmetic patients under 24 hours, you will incur a charge of 20% of your treatment total. If cancellations are under 4 hours or no shows, the charge is 50% of your treatment total.

By signing below, you state that you understand the above financial agreement & agree to pay and /all remaining balances due for your services/treatments/lab tests rendered at Kenner Dermatology Center within 30 days of receipt of your billing statement.

Print Name

Signature

Date

FOR OFFICE USE ONLY:

Initial

Date