HECKER DERMATOLOGY GROUP, P.A.
3500 NE 5TH AVENUE
POMPANO BEACH, FL 33064
(954) 783-2323 FAX (954) 783-2321
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PATIENT FINANCIAL RESPONSIBILITY FORM

Disclosure Statement

Please place your initials by the X marked spaces below, signifying your willingness, understanding, and compliance with the following policies.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, or staff is trained to consistently inform you of the financial payment policies of this office. **WE DO NOT BILL PATIENTS**. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. Payment for cosmetic products will **NOT** be billed under any circumstances.

Patient Initials X_____

As a courtesy to you, we will file to a participating insurance company for services our medical providers rendered today. Once payment is received, we will adjust certain balances according to our contracts with your insurance carrier. If we do not have a contract with your insurance company, you will be responsible for payment **at the time of the service.** Should we receive payment from your insurance company, you will be refunded in a timely manner. You are considered a cash patient until you bring in completed forms, AND this office qualifies and accepts your coverage.

Patient Initials X_____

For those patients, applicable co-payments and deductibles will be collected at the time of visit. **WE DO NOT BILL PATIENTS FOR DEDUCTIBLES OR CO-PAYS.** We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be verified and you will be asked to pay any remaining deductible, non-covered services, and co-payments. In the event that your check is returned, a $40.00 fee will be added to your account.

Patient Initials X_____

I am responsible for providing a copy of my current insurance card to the *Hecker Dermatology Group* office upon every visit. If my current insurance information is not presented, it will be my responsibility to file with the proper insurance company and pay *Hecker Dermatology Group* in full for services provided. **IT IS THE PATIENT'S RESPONSIBILITY TO KNOW IF THEY ARE OUT OF NETWORK AT OUR PRACTICE.**

Patient Initials X_____

You are responsible for taking an active part in the recovery of your insurance claim. After 45 days, you will be responsible for payment in full for any outstanding balance. After 45 days, you authorize us to use your personal credit card to collect payment in full. In addition, any account over 45 days or more past due will incur 1.5% per month in additional fees from the date of service.

Patient Initials X_____

If I do not make payments, and my account is sent to an external collection agency, I understand and agree that I will be responsible for all charges incurred by *Hecker Dermatology Group* from its agent (including but not limited to legal fees) in order to collect on the debt.

Patient Initials X_____

It is our policy to keep a copy of a credit card on file for outstanding balances. This is a result of increasing difficulty with collections. Your credit card will only be charged after 45 days if the patient's portion of the medical bill is not received (I.E. co-pay, deductible, etc.). We will not bill for any portion of the charges that are covered by your insurance. The physician will only be able to see you with a credit card on file. **At the time of appointment, please provide the front desk with your picture ID, insurance card(s), and a major credit card.**

Patient Initials X_____

Patient Signature X_____Date_____

HDG Representative Signature:_____Date_____