Financial Policy-CSD

Self Pay: All services shall be paid in full at the time of service.- *A discounted fee schedule based on BCBS rates is offered to Cash patients.*

Cosmetic procedures: All services (e.g. Botox and Fillers) shall be paid in full at the time of service. The removal of Skin Tags, Non-inflamed Seborrheic Keratosis, Sebaceous Hyperplasia, certain types of Milia, and DPN's (Dermatosis Papulose Nigra) are considered cosmetic.

Commercial Insurance: All copays are required at the time of visit.

Assignment of Benefits: I authorize payment directly to Craig Singer MD Dermatology (CSD) for all benefits otherwise payable to me. I acknowledge that CSD will submit a claim to my insurance carrier as a courtesy; however, I understand that I am ultimately responsible for all deductibles, coinsurance, copayments, out of network penalties and non-covered services. I agree that I will pay my estimated balance today based on the information available from my insurance company and I understand that CSD does not guarantee payment of any claim until it has been fully processed by my insurance carrier. I understand it is my responsibility to obtain an authorization required prior to treatment.

Managed Care: I understand that if my insurance is an HMO, a referral is required at the time of each visit. I understand that I am responsible to obtain a referral from my primary care physician. *If I have not obtained the proper referral, I will be required for payment in full at the time of the visit.*

Medicare: Craig Singer MD Dermatology, PLLC (CSD) is a participating physician group and will file your claim for you. Today you will be responsible for "your part" which is 20% (unless you have an approved supplemental policy) plus your unmet deductible for the current year. I request that payment of authorized MEDICARE benefits be made on my behalf to CSD for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I have not pledged or assigned my benefits to any Health Maintenance Organization (H.M.O.).
I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me.

Pathology/ Lab: Biopsy specimens and bloodwork will be submitted to an outside laboratory for evaluation. You will receive a separate bill from the laboratory for services rendered. If your insurance requires us to send specimens to a specific laboratory, it is your responsibility to inform us.

Patient Name: _____

Signature: _____ Date: _____