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 cosmetic 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 for obtaining 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.

If you fail to pay your bill within 60 days, your account will be submitted to Congress Collection Agency and we will assess a 30% surcharge to your balance to cover the cost of recovering payment.

Patient Name: _____

Signature: _____ Date: _____