NEIMAN
DERMATOLOGY AND
HAIR TRANSPLANTATION

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ACKNOWLEDGEMENT AND UNDERSTANDING OF FINANCIAL POLICIES

Initial: _____ I understand that for a deductible or co-insurance related plan, I will be asked to pay $100 at the time of service for any office visit. If I have met my deductible and am now responsible for a percentage, I expect to pay $25 towards the office visit or my required co-pay.

Initial: _____ I understand my responsibility as a patient, and that it is my responsibility to check on my insurance coverage prior to being seen. I, as the patient, am responsible for checking on referral necessity and copayment amounts for a specialist. I understand that I should have full knowledge of payment, or non-payment, of my health insurance premiums, and whether my insurance is in effect or not.

Initial: _____ I understand that if my insurance is not in effect, will not cover a specialist, requires a referral that I do not have, I am being seen for a non-covered service or procedure, or I do not have health insurance, I will be considered a self-pay patient for that visit. If my insurance will cover part of my medical services, but will not cover them entirely, I may be charged for a self-pay portion of my visit, while another part of my visit will be sent to my health insurance for coverage.

Initial: _____ I understand all statements regarding bills for patient responsibility being sent out to me. I understand that I may be liable for any additional administrative fees in relation to my office visit, including, but not limited to, returned or stopped payment fees, missed appointment fees, and/or collections fees.

Initial: _____ I understand that I have the right to request evaluation of any potential medical treatment, and that I may refuse treatment the same day and wait for an insurance determination of coverage for said treatment. I may also choose to move forward with a medical treatment that may not be covered by my medical insurance plan, and pay outright for the service the same day.

Initial: _____ I understand that I have been requested to keep an up to date credit card on file to help keep my account balance up to date.

(Please Circle One:)

I Refuse / I Allow my credit card information to be held on file in the office.

Initial: _____ [If I allow my credit card information to be held on file in office:]
I understand that I will be notified before any charges are put through on my credit card held on file, and that notification can include: 1) explanation of amount, and 2) reasons for any balance.
I understand that I can request a review of my account if I believe my card was run or charged in error.

Initial: _____ I have reviewed the financial and office policies provided to me by the staff at Neiman Dermatology and Hair Transplantation.

I have spoken with a staff member of Neiman Dermatology and Hair Transplantation, and have had my questions and concerns addressed.

_____ _____
Patient Name Date

_____
Signature of Patient or Responsible Party