

CHRISTOPHER R. HUBBELL, M.D.

Financial Policy

- Payment is required for all services at the time they are rendered (unless you have made prior arrangements for a hardship payment plan.) Acadiana Dermatology, APMC accepts payment in the form of cash, checks, Visa, Mastercard, Discover and American Express.
- If a check is returned to the office due to insufficient funds, the original check amount plus a \$25 returned check fee must be received within 30 days from the date the check was returned to avoid further late fees or collection action.
- In the event that a patient's balance becomes more than 45 days past due, a late fee may be assessed.
- After a balance has reached 90 days past due, your account will be turned over to an outside collection agency for further action. The patient will be responsible for any charges incurred in such action.
- Please help us better serve you and our other patients by keeping all scheduled appointments. If you must change an appointment, please do so before 24 hours prior to your scheduled appointment time. The charge is \$25.00 for any missed appointment without receiving a notice prior to 24 hours of your appointment.
- Lab tests and/or Pathology specimens sent to outside laboratories will be billed separately from Acadiana Dermatology's charges. The laboratory service will bill for their charges

PATIENTS WITH PRIVATE INSURANCE

Acadiana Dermatology is pleased to participate in a number of different insurance plans. While we are pleased to be able to participate in these plans, it is impossible for our office staff to be aware of each plan's specific requirements. Your plan may have limitations on the frequency of services performed or where service may be performed. Some plans may require a referral from your primary care physician as well. It is the patient's responsibility to inform Acadiana Dermatology of specific limitations set forth by their insurance plan(s). If Acadiana Dermatology is to order services that are considered non-covered by a patient's insurance carrier, payment for these services becomes the financial responsibility of the patient.

Due to the overwhelming number of insurance plans, it is impossible for our office staff to guarantee coverage by any individual plan. It is your responsibility to verify that we are a member of your network before presenting to our office for treatment. It is in your best interest to verify this information directly by calling the customer service number on your insurance card before being seen by a new health care provider.

If we participate with a commercial insurance plan under which you are covered; we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of your annual deductible, co-payments, and any non-covered or cosmetic charges. In the event that we are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

For those patients who have chosen a medical insurance plan what we do not have a contractual relationship with; we require payment in full at the time of service. You will be responsible to file the charges for your treatment with your insurance company and we will give you a fee bill that contains all the necessary codes and information that you can file with your insurance plan for reimbursement. It is your responsibility to verify that you have insurance coverage for any services rendered to your from Acadiana Dermatology, APMC

PATIENTS WITH MEDICARE

We are Medicare participating providers. We will bill Medicare and Medigap (Supplement) carriers. You will be responsible at the time of service for payment of the annual deductible, co-payments, co-insurance (20%) and charges for non-covered or cosmetic services.

Your signature below signifies that you understand our financial policy and agree to the terms of your responsibility regarding charges incurred at this office

PATIENT SIGNATURE OR GUARDIAN _____ DATE _____