Dermatology Center for Skin Health
600 Suncrest Towne Centre, Suite 115
Morgantown, WV 26505

Financial Agreement

To our patients: We are pleased you have placed your trust in us to care for your skin problem(s). We look at this as an honor and privilege, but above all a responsibility to you and to God. A responsibility we will strive to fulfill to the best of our abilities on all levels: medical, financial, and even social. This can only be done as a concerted effort and in harmony with you, your family, and with our team.

This agreement is part of our commitment to work with you on the financial aspects regarding the dermatology care you receive.

The following is provided to avoid any misunderstanding or disagreement concerning payment for services rendered at the Dermatology Center for Skin Health.

Our Responsibility to Our Patients

1. As a courtesy, we agree to do the initial billing to your insurance company or companies.
2. If insurance payments are not received within 30 days from the date of service, we will follow-up with your insurance company to see why the claim has not been processed, or why a denial was received.
3. Co-payments will be collected at the time services are rendered.
4. Any un-paid balances left by your insurance company will be your responsibility.
5. If you do not have insurance coverage, payment is expected at the time of service. If your account becomes delinquent, it will be listed with a collection agency, and you may be dismissed from the practice.
6. We accept cash, check, and credit card payments for services rendered. Credit card payments can be made by telephone.
7. A $25 Service charge will apply for all returned checks.
8. Monthly Statements will be mailed with payment due upon receipt; no payment will result in collection proceedings.
9. We will answer any questions you may have regarding your account. If you want someone, perhaps a family member, to call about your account, you must list the person's name and date of birth on your HIPAA form. Otherwise, no information will give regarding your account.

Patient's Responsibility to the Dermatology Center for Skin Health

1. Your insurance coverage is an agreement between you and carrier(s). It is your responsibility to remit payment for services not covered. If payment is sent directly to you from your insurance company, it is also your responsibility to

forward those payments immediately to us. Failure to do this will result in Insurance Fraud.

2. It is your responsibility to contact our office if any of your demographic information (i.e. address, phone number) has changed.

3. If you, at anytime, experience a set of circumstances out of your control that will keep you from fulfilling your financial obligation to the Dermatology Center for Skin Health, you must contact our office and we will be willing to help you.
4. If your insurance company requires pre-authorization or referrals before seeing a specialist, or if you are unsure whether Dr. Maouad, Dr. Gharib, or the Nurse Practitioner is a participating provider with your insurance, you must contact them prior to your visit with us.
5. It is your responsibility to provide us with any information regarding any changes in your medical insurance-new cards, new coverage, discontinued coverage, etc. Failure to present a valid insurance card at time of service will result in **$100 self-pay fee** for visit.

I, the undersigned, hereby confirm that I have read and understand this Financial Agreement given to me by the Dermatology Center for Skin Health.

I hereby confirm my responsibility for services rendered by the Dermatology Center for Skin Health. I understand that any attempt to collect from my insurance is strictly a courtesy to me.

In the event that the services rendered are not covered by my insurance, or not paid within 90 Days, the account is solely my responsibility.

A $25 "No Show" fee will be charged for any scheduled visits that are not cancelled within 24 hours.

Print Name: _____

Signature: _____ Date: _____