DERMATOLOGY SOUTHWEST

Financial Policy And Disclosure

Please Sign and Date

The Financial Policy and Disclosure is to help M. Basem Chaker, M.D. provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Self-Pay Policy:

- If you are a self-pay patient, you will be required to pay your balance in full at the time of service.
- If you are unable to pay the balance at the time of service, a financial agreement may be established and must be agreed upon prior to provision of services.

Insurance Policy:

- If you are an insurance patient, we require the coverage to be verified for each patient at least once per calendar month. If the coverage cannot be verified, we require you to leave credit card information so that once the coverage is verified we may process the patient responsibility portion to your credit card.
- It is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- If we have not received a payment from your insurance company within thirty (45) business days, you will be responsible for the balance due.
- Deductibles, co-payments, and coinsurance will be collected at the time of service.
- In special cases, we may need your help in contacting your insurance company for the payment of your services and therefore you must agree to fully cooperate in assisting us should that be necessary.

TO HELP IN THIS POLICY WE ASK THAT YOU ASSIST US BY:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, co-pay, coinsurance, or for the full amount if you are a Self-Pay Patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the check-out associate, front desk associate, office manager &/or billing associate.

_____	_____	___/___/___
Patient Signature (or Legal Guardian)	Printed Name	Date
_____	_____	___/___/___
Witness Signature	Printed Name	Date