Cosmetic Dermatology and Vein Centers

Acknowledgement of Financial Policy

Due to rapid changes in insurance company policies and privacy regulations, it is not always possible for us to accurately obtain or confirm your benefits, deductibles, and co pays. It is ultimately your responsibility to be aware of your contract benefits. Please feel free to inquire if you have any questions.

Patient or Guardian Initials_____ **Date**_____

Please also note that due to HIPAA (Health insurance Portability and Accountability Act) and other federal regulations, we require that you review our financial policy.
We ask that you review our financial policy prior to signing it.

Patient or Guardian Initials_____ **Date**_____

A 1.5% per month late fee will apply on the amount of any account 30 days overdue.

There will be a $25 fee charged for any returned check.

Patient or Guardian Initials_____ **Date**_____