BORTNICK
PLASTIC SURGICAL ARTS

A DIVISION OF
DERMATOLOGY & SKIN CANCER CENTERS

Thank you for choosing Dermatology and Skin Care Center Specialists and Skin & Mohs Surgery Center as your health care provider.

The following is a statement of our **Financial Policy**.

IF YOU HAVE HEALTH INSURANCE COVERAGE…

- You are responsible to supply us with correct, current insurance info.
- Please notify us of any changes in your address or telephone number.
- ALL copays are due at the time of service.
- Referrals are your responsibility and must be current prior to your visit.
- Your estimated portion, including any deductibles, will be expected at the time of service (our business office will notify you in advance if this is required).
- You may not self pay, and then ask us to file your insurance at a later time.
- You are ultimately responsible for payment of all charges whether or not such charges are covered and paid (either fully or partially) by your insurance company.

IF YOU DO NOT HAVE HEALTH INSURANCE… or IF YOU REQUEST A COSMETIC PROCEDURE…

- Payment in full is due two weeks prior to service. Surgery may be postponed or cancelled if prepayment is not received.
- We accept cash, check, VISA, MC and Discover.
- Cosmetic consult fees will be applied to the cost of your procedure.

Our business office is available from 8:00am-5:00pm Monday thru Friday to answer any questions or address any concerns you have. If you receive a statement from our office, then we expect payment from you. If you disagree with the balance for any reason please contact our business office immediately at 913-754-4944.

* A parent who brings a minor child to our office for medical care is responsible for payment of all of the child's charges.
* A $25 is charged for returned checks.
* A **Cancellation fee** of 25% will be charged for cancellations made less than three working days prior to surgery.

I hereby guarantee payment of all charges for medical treatment and services provided to me (or my dependent) by Dematology & Skin Cancer Specialists, PA or Skin & Mohs Surgery Center, Inc. I understand and agree that if the office places my account with an agency or attorney for collection, the office shall be paid by me for all collection costs to the extend allowed by applicable law.

I HAVE READ AN AGREE TO THIS FINANCIAL POLICY:

_____ Date: _____
Signature of Patient or Responsible Party