**FINANCIAL POLICY**

Your Signature below forms a binding agreement between Spring Hill Dermatology, PLC (provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

**All charges of services rendered are due and payable at the time of service.**

The person signing on behalf of the patient as the Responsible Party must:

* Inform Spring Hill Dermatology, PLC of the current address and phone number for the patient and the responsible party.
* Present all current insurance cards prior to each office visit.
* Verity at each visit that the information is current upon check in for appointment.
* Pay any required co-pay at the time of visit.
* Pay any additional amount owing within 30 days of receiving a statement from our office. (When Spring Hill Dermatology, PLC receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you.)

All specimens are either sent to our in-house lab with Dermatopathologist, Benjamin B. Hayes, MD PhD or sent for pathology testing to an outside laboratory such as PCA Southeast or Pathology Associates of Saint Thomas, LLC. Neither of these groups are affiliated with Spring Hill Dermatology, PLC and you may receive a separate bill.

**Return Check Policy:**

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the Patient or patient’s Responsible Party will be responsible for the original check amount in addition to a $25.00 service charge. Once notice is received of the returned check, Spring Hill Dermatology, PLC will send a new statement reflecting the returned check and service charge. If a response is not made within 15 days from the letter date by the Patient or Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 returned check service charge.

**Non-Payment on Account:**

Should collection proceedings or other legal actions become necessary to collect an overdue account, the Patient or patient’s Responsible Party, understands that Spring Hill Dermatology, PLC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient, or patient’s Responsible Party, understands that they are responsible for all cost of collections including, but not limited to, court cost and Attorney fees, and a collection fee will be added to the outstanding balance.

**Credit Card on File:**

The Patient or patient’s Responsible Party authorizes Spring Hill Dermatology, PLC to charge my credit or debit card for agreed upon purchases or payments. The signature below indicates understanding that the credit or debit card may be stored on file for future payments.

By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services, or as the Responsible Party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

**Patient Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Responsible Party Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**