(PLEASE PRINT) **INSURANCE INFORMATION**

INSURANCE COMPANY NAME ______________________________________________

INSURANCE COMPANY ADDRESS (IF NOT ON CARD) ______________________________________________

POLICY HOLDERS NAME ____________________ POLICY HOLDERS DATE OF BIRTH ____________________

ID# ______________ GROUP # ______________ RELATIONSHIP TO PATIENT ____________________

## SECONDARY INSURANCE

INSURANCE COMPANY NAME ______________________________________________

INSURANCE COMPANY ADDRESS (IF NOT ON CARD) ______________________________________________

POLICY HOLDERS NAME ____________________ POLICY HOLDERS DATE OF BIRTH ____________________

ID# ______________ GROUP # ______________ RELATIONSHIP TO PATIENT ____________________

## KNOXVILLE DERMATOLOGY GROUP, P.C. FINANCIAL POLICY

We at Knoxville Dermatology Group are committed to providing you the best possible care at the most reasonable cost. If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of your payment policy.

All charges are due at time of service. This includes co-payments and deductibles. We accept cash, check, Visa, MasterCard, Discover, and American Express. In cases where there is not adequate insurance coverage, we understand medical expenses can be a financial burden. Notify us in advance and we will assist you in whatever way we can.

INSURANCE: We will gladly discuss fees for your proposed treatment and answer questions relating to your insurance. Please realize, however that your insurance is a contract between you and the insurance company, and you are financially responsible for any services or deductibles not covered for payment under your insurance plan. Patients covered by carriers that list out physicians as participating physicians must follow the guidelines specified in their policies, particularly with regard to referrals.

Some services may not be covered under your contract. Please check with your insurance company if you have any questions regarding which services are covered. You are responsible for these services if the insurance company does not pay.

BILLING, PAYMENTS, AND OVER PAYMENTS: If an overpayment is made by you on your account, a refund will only be issued if there are no other outstanding debts on other accounts containing the same guarantor or financial responsible party. Patient charges unforeseen at time of service will be billed to the address you have provided for billing purposes. It is your responsibility to inform us of any change in address, phone or employment. All balances are due in full within 14 days of the billing date. If you cannot pay this balance in full within 14 days, please contact our office to see if you qualify for any special payment arrangement options.

PAST DUE AND DELINQUENT ACCOUNTS: Failure to meet your financial obligations may result in reporting you to the credit bureau or other collections action against you.

My signature below certifies that I have read, understood, and agree with the terms set forth in this Financial Policy.

PATIENT SIGNATURE ______________________________ DATE ____________________