Financial Disclosure Statement

Thank you for choosing Dean Derm. You can expect to receive the following bills as a result of your visit:

- Physician Fee: Fee to be paid to the physician for performing the service. This bill will be from Dean Derm.
- Lab Fee: If a lab test is ordered, a second bill will come from an outside lab.
- Pathology Fee: When a pathology test is ordered, a second bill will come from an outside pathology lab.

Insurance: Your insurance company will send you an Explanation of Benefits (EOB) that will explain how the insurance company paid your bill. The EOB will also explain any amount for which you may be responsible. Some insurance plans require you to pay different out of pocket amounts based on where the service is performed. Deductibles, co-insurance and co-payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. Dean Derm will submit primary, secondary, and tertiary claims for our contracted payers on your behalf. As long as the information needed to process the claim is obtained and verified before your visit. If this information is obtained after your visit, the patient or guarantor is responsible for the balance.

Co-payments: Dean Derm collects co- payments at the time of service. Additional payment may be required based on your insurance plan. In the event your account has a credit, a refund will be issued in a timely manner.

Refunds: All refunds will be processed within 3 -5 weeks after the overpayment is discovered on the patient's account or at the time the refund is requested. Patients who have insurance but made a partial payment or payment in full will not be refunded until payment is received in full from their insurance company. Refunds for prepaid events will be processed within 5-7 business days. For refunded payments a check will be issued to the patient.

Initial below:

_____If we are unable to verify you have active coverage on the date of your appointment you will be required to pay for the visit in full the time of service. If your insurance later pays for your visit we will issue you a refund.

_____A $25 fee will be incurred for returned checks.

_____In the event we need to contact you regarding a billing matter, we may call you on your cell phone if you have listed this number as your primary or alternative contact number.

Additional questions regarding billing or payment arrangements should be directed to our billing department as follows:

Call the office at 318-321-5245 and ask to speak to the billing department.

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No-Show or Untimely Cancellation of Appointments

_____If you are unable to keep your appointment, please cancel at least 48 hours in advance to allow time to schedule other patients who are waiting for appointments. If they are not cancelled prior to 48 hours or no-show appointments will result in **a $25 fee for a routine medical visit and a $50 fee for surgery time slots.**

_____**For laser procedures (TRL, Profrac or Halo)** a 10% down payment is required at the time the appointment is scheduled. This amount will be applied to the procedure. However, if you are unable to come to your appointment it must be cancelled a week prior to the appointment, or the down payment is forfeited.

_____**For laser and aesthetic procedures (BBL, BBL HEROic, or SkinPen)** a $50 deposit is required at the time the appointment is scheduled. This amount will be applied to the procedure. However, if you are unable to come to your appointment it must be cancelled a week prior to the appointment, or the down payment is forfeited. If a package is purchased, the $50 down payment will cover the first untimely cancellation or no-show appointment. If you miss subsequent appointments without canceling in a timely fashion or no-show to those appointments, then $50 fee will be applied to each missed appointment.

Patients Reassignment and release statement

By signing below, I indicate my understanding of Dean Derm's billing practices and that I may receive multiple bills related to my office visit as explained above. I authorize payment of medical benefits to PDA and authorize them to release any medical information necessary to process claims. I understand that I am financially responsible for any co-payments, deductibles, co-insurance and non-covered services as outlined by my health plan. This agreement applies to all visits that take place one year from the date this is signed, and any bills resulting from those visits.

Patient/Guarantor Signature*_____ Date: _____

*If a patient is a minor (under the age of 18), form must be signed by a parent or a legal guardian.