FINANCIAL RESPONSIBILITY

Welcome to our office. We take great pride in informing our patients of all aspects of their care, and want to clarify the following terminology relating to the financial responsibility for your care.

CO-PAY
The co-pay is an amount that your health plan requires you to pay any time that an office visit is billed. This payment is due on the date of service.

ANNUAL DEDUCTIBLE
An annual deductible is an amount that your health plan requires you to pay toward your health care costs each year. If you have not met that deductible at the time of service at our office, you will be responsible for payment on that date. We will be able to assist you in determining the amount of your deductible that has been paid to date. If you have Master Medical, you receive a check directly from the insurance company, and therefore, you are responsible for payment to our office for your services.

BALANCES
If you have paid your deductible, we will bill your insurance for the services provided to you, and should there be a balance due from you after the insurance pays the claim, we will subsequently bill you for the balance.

PATIENTS WITHOUT INSURANCE
If you do not have insurance, you are responsible for the payment of services on the date of your visit.

COSMETIC SERVICES (NOT COVERED BY INSURANCE)
You are responsible for payment of cosmetic services on the date of your visit.

WHEN REFERRALS ARE REQUIRED
Some plans require that your primary physician write a referral to a dermatologist, which indicates which conditions are to be evaluated and treated. If you are unsure if a referral is necessary, please check with our office. If required, it may be faxed or mailed, to be received prior to your visit, or you may bring it with you on the date of your visit. The referral cannot be obtained after the service is provided.

LABWORK
We may need to send biopsy/skin specimens to a lab, as well as order additional lab tests. If your insurance company requires the use of a particular lab, it is your responsibility to inform us at the time of service, so that you may obtain the appropriate reimbursement.

We realize that insurance and billing issues can be confusing, and if you have questions regarding your financial responsibility for payment, please do not hesitate to contact our office. In addition, your Explanation of Benefits (EOB), mailed to you from your health plan, will detail the covered and uncovered portions of the visit. We are committed to working together to have the most current information and appropriate reimbursement for you.

I have read, understand, and agree to my responsibility.

Signature:_____Date:_____

Mail to: Sadoff Dermatology PC, 31360 Northwestern Highway, Farmington Hills, Michigan 48334
or Fax to: 248.855.3319