UPTOWN DERMATOLOGY, P.A.
Elizabeth A. Mullans, M.D.
2211 Norfolk Street, Suite 200
Houston, TX 77098

FINANCIAL POLICY

Thank you for choosing our practice. We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

Please acknowledge by initialing each of the following numbered items:

1. _____If we participate with your managed care plan or you have a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for the payment of the co-payment, co-insurance, deductible and/or charges for non-covered or cosmetic services.

   In the event that we are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier. Your account will be turned over to a collection agency if any remaining balance is not paid in full within 60 days of the date of the first billing statement.

   Please be advised that anything you choose to have removed or biopsied may not be covered under your office co-pay and may be subject to your deductible and/or co-insurance. We will make every effort to contact your insurance to verify your benefits, but in the event we are unable to reach them, you will be responsible for your co-payment, deductible and/or co-insurance as well as payment for any procedures performed. Such procedures includes: **injections, biopsies, scrapings/shavings, destructions (freezing), or excisions of lesions or growths, etc.**

   HMO patients and some managed care patients are responsible for obtaining the necessary referrals prior to their appointments. Unauthorized (referrals not received) services are the patient's responsibility, and full payment for these services is expected at the time of service.
2. _____We do not accept Medicare.
3. _____If you do not have health insurance, payment is expected in full at the time of service.
4. _____In the event we receive a returned check due to insufficient funds, a fee of $25.00 will be charged to your account, and payment is due upon receipt of your statement.
5. _____If you purchase skin-care products or supplies from our office, please understand that these products/supplies are a non-refundable item. In the event the product/supply is defective, we will gladly replace the item(s).
6. _____ ***We request that you give us at least 24 hours notice, if you are unable to keep your appointment. Failure to give 24 hours notice will result in a $60.00 missed appointment fee. This fee is not covered by your insurance plan.***

For your convenience, we accept cash, check, MasterCard, Visa, American Express and Discover.

Your signature below signifies that you understand our Financial Policy and your responsibility regarding charges incurred in this office.

_____ _____

Patient/Guardian Signature Date