c h i c a g o
COSMETIC SURGERY AND DERMATOLOGY

Patient Name: «Person_First_Name» «Person_Last_Name»
ID: «Person_ID»

20 West Kinzie Street ● Suite 1130 ● Chicago, IL 60654
P 312-245-9965 ● F 312-245-9964 ● chicagodermatology.com

Financial Policy

Thank you for choosing Chicago Cosmetic Surgery and Dermatology as your health care provider. Our primary mission is to provide our patients with outstanding medical care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Carefully review the financial policy information and return it with your signature and today's date. Please ask if you have any questions about our fees, our policies and/or your responsibilities.

- We accept cash, checks, Visa, MasterCard, Discover and American Express.
- Your bill might include office visits, destructive treatments, biopsies, injections, and removal of benign/malignant lesions, pathology or other charges.
- You may also receive bills from outside pathology and laboratory clinics that we utilize.
- All co-payments must be paid at the time of service.
- If you do not have insurance, payment in full is expected at the time of your visit.
- Any balances not paid are subject to the terms and conditions stated in the CCSD Credit Card Authorization Policy.

Insurance:
It is the patient's responsibility to provide the clinic with current insurance information.
Our relationship is with you, not your insurance provider. Please check with your insurance provider to ensure our providers participate with your network.
Failure to honor any agreements may result in your account being placed with a collection agency. Please note additional fees will incur.

Referrals:
If you have an insurance plan that requires you to have a referral to be seen in our office, it is your responsibility to obtain an electronic referral letter from your primary care physician and present to our office when services are rendered. Please be aware that handwritten referrals are no longer acceptable.

Minors:
The parent/guardian that signs this Patient Financial Policy will be responsible for payment on the minor's account, regardless of who is the primary policy holder of the insurance.

Miscellaneous Fees:
- If you fail to cancel your appointment prior to 24 hours of the time your appointment is scheduled, you may be charged a $25 fee.
- If you fail to cancel your surgery (including excisions, Mohs surgery) appointment and/or laser appointment prior to 24 hours of the time the surgery or laser is scheduled, you may be charged a $50 fee.
- The no-show fee for a scheduled appointment is $25.
- All cosmetic quoted procedures will be subject to the terms, conditions, cancellation policy and cancellation policy fee of that quote.
- There is a $35 fee for any check returned for insufficient funds.

Insurance Information Release Authorization:

I hereby authorize Chicago Cosmetic Surgery and Dermatology to release any information acquired in the course of my examination or treatment to my referring health care provider and/or my insurance company.

I read, understand and agree to this policy.

_____ _____
Patient Name (Please Print) **Patient or Responsible Party Signature**

_____
Date