TruDerm

Adult & Pediatric Dermatology & Cosmetic Center

Our Financial Policy

We are committed to providing the best care possible for you. Having an understanding of your financial policy will keep our collective focus on you and your health.

1. We require a 24-hour cancellation notice. Any patient that misses an appointment without notifying a front office staff member of TruDerm PA by phone, is considered a "No Show" and we reserve the right to charge a cancellation fee of $40.

2. Copays must be paid on the date of service. The copay is your responsibility and is decided by the insurance company.

3. All patients under 18 must be seen with a legal guardian or parent or have written permission from them to be seen by an adult who can make medical decisions on their behalf.

4. As a part of our care to you, we will file your insurance claim. If your insurance does not pay the practice within 90 days, you are responsible for your outstanding balances. If your insurer sends a check later, we will refund any overpayment to you.

5. Subsequent appointments cannot be made for patients with outstanding balances greater than 90 days.

6. HMO patient's: we will do our best to notify you before your appointment if you need a referral or authorization, however, you are ultimately responsible to make sure your referral is valid and to date.

7. For self-pay patients, we do not accept personal checks, we accept Mastercard, American Express, and Visa. There is a $35 service fee for returned checks.

8. Please note that although you're receiving care in an office setting, many insurances consider biopsies, removals to have "surgical benefits" and may be subject to their own deductibles.

I have read and understand the financial policy for TruDerm PA. I agree to its terms and will immediately notify the office if there are any changes to my address, phone number and insurance coverage. I understand that I am responsible for knowing about my insurance benefits including deductibles, co-payments and non-covered services.

Signature of patient (or responsible party): _____

Date: _____ Print Patient Name: _____