

Nicole Vessels Brey, MD PSC

FINANCIAL POLICY

Thank you for choosing NVB for our dermatological care. Your health is our greatest priority. Of course, as with any business, we must reconcile our financial relationship as well. Patients have access to a variety of health care plans, and our financial relationship is dictated primarily by the health plans that you, the patient, choose. Many of you have selected plans that have co-payments and deductible, and it is our responsibility to collect those fees *at the time of each visit* to our office. Our contract with your insurance carrier REQUIRES us to make these collections. We appreciate your cooperation with our staff in this regard. If you have questions about this process, please contact your insurance company.

Payment

Payment in full is due at time of service. Co-payments will be collected at the time you check in the office. Patients who have not met their deductible will need to satisfy that amount before treatment is rendered. Co-insurance due for extensive care will be determined when benefits are verified and that co-insurance amount will also be due at the time of service.

Insurance

We file your insurance claim as a courtesy. Ultimately, expenses incurred are the responsibility of the patient. Should your insurance company deny your claim or not respond to our collection efforts, payment will be expected from the patient.

Unpaid Balances

A fee of \$50 will be assessed on any check returned or otherwise not honored by your bank. This fee is due IN CASH CURRENCY when you come to the office to retrieve the original check.

Collection Accounts

In the event that my account is released to a collection agency, I agree to pay all collections costs, court cost and attorney's fees incurred to collect my account.

Missed Appointment Policy

We ask that you cancel or reschedule appointments with a 24 hour advance notice. Failure to notify the office of cancellation will result in a \$25 charge to your account. If you arrive more than 15 minutes late for your appointment, we will ask you to reschedule in consideration of our other patients.

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

Patient Signature

Date

Witness

Date