

FAIR OAKS SKIN CARE CENTER

3700 Joseph Siewick Drive, Suite 403, Fairfax VA 22033

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INSURANCE AND BILLING POLICY

Welcome to our office. The doctors and staff are pleased that you have selected us and are here to help you in any way we can. The following information outlines our office policies. We hope this will be of help to you. If you have any questions, please feel free to ask.

If you have health insurance that we are contracted with, this office will bill your plan directly. We use the services of an independent billing contractor. If you have health insurance that we do not contract with and are a self-pay patient, this office will bill your plan directly for an administrative fee of \$10.00, plus the cost of services rendered on that day. Fees that you are contractually responsible for at the time of the visit, such as, but not limited to, co-payments are payable at the time of the office visit.

Balances:

Balances must be paid within 30 days of receipt of the billing statement. Balances over 30 days will have a \$10.00 fee added to them. If it is necessary to turn the account over to a collection agency, a 33% collection fee in addition to any attorney fees incurred will be added to the outstanding amount and the collection agency may report a negative credit report to a credit-reporting agency. In the event of a returned check, a \$35.00 charge will be assessed.

Fees:

There will be a charge for a **NO-SHOW** or a **MISSED APPOINTMENT** without 24-hour prior notification for specific visits:

Medical – \$75.00

Cosmetic-\$100.00

Surgical- \$150.00

There will be a \$30.00 fee assessed with any **prior authorizations, medical forms to be completed, letters of medical necessity or other written documents requested by the patient.** There will be a charge of \$15.00 for any **prescription refills** that have been lost, called into an out of state pharmacy, multiple prescriptions for 90 day mail-order, or not requested at the time of a visit.

I acknowledge that any benign skin lesions, skin tags, and/or freezings may not be covered by my insurance or go toward my deductible. I will be responsible for any charges not covered by my insurance.

I have read and agree to the above terms. I hereby authorize Fair Oaks Skin Care Center to file claims and receive payment for services directly from my insurance carrier. Should certain services be deemed not covered by my insurance carrier, I will assume responsibility for paying these services.

Patient Signature

Date