c h i c a g o
COSMETIC SURGERY AND DERMATOLOGY

FINANCIAL POLICY AUTHORIZATION - Effective date January 10, 2022

- I understand that I must present valid evidence of insurance coverage along with valid government issued identification. _____Initial
- I grant permission to bill my insurance provider and authorize payment for services rendered to me to be paid directly to CCSD. _____Initial
- I understand CCSD will make an attempt to verify eligibility and benefits prior to my visit. In doing so, CCSD will collect any estimated out of pocket expenses, such as; services that may be **applied towards my deductible**, **subject to copayment or coinsurance**, in which case will be my financial responsibility and collected *at the time of service*. _____Initial
  Disclaimer: *CCSD cannot guarantee the verification of eligibility and benefits or expected payment conveyed to us or to you by your insurance provider will be accurate or complete. Benefits and payment are subject to all terms, conditions, and exclusions of the member's contract at the time of service. We strongly suggest you have an understanding of your insurance benefits and monitor your account with our office.*
- I understand if my insurance provider delays or withholds payment, for 90 days or longer, the balance due will become my financial responsibility. _____Initial
- I understand if I fail to: obtain a referral (if required), pay my insurance premium, or coordinate my benefits, I will be financially responsible for my services. _____Initial
- I understand I may incur separate billing charges for pathology and/or laboratory services from our office or the facilities we utilize. _____Initial
- I understand Self-Pay patients, or patients seeking care outside of utilizing their insurance benefits, are expected to make payment in full at the time of service. _____Initial
- I understand that if I am unable to keep an appointment, I must provide the minimum of a 24-hour business day notice otherwise the following fee will apply: **$25** for *general dermatology appointments*, **$50** for any *cosmetic or aesthetics appointments*, **$100** for *surgical procedure appointments*. In addition, any required deposits taken for procedures or Saturday appointments will be forfeited if appropriate notice is not received. All quoted cosmetic procedures will be subject to the terms, conditions and cancellation policy fee of that quote. _____Initial

Our facility will require that you maintain a valid credit card in our PCI compliant secure database for all services that are billed to your insurance carrier.

CHECK ONLY ONE OPTION:

Credit Card Option:

☐ I wish to secure a credit card and authorize Chicago Cosmetic Surgery & Dermatology and Chicago Skin Science to charge any balances due on my account.

☐ ***PLEASE CHECK IF YOU WOULD TO BE NOTIFIED PRIOR TO THE PROCESSING OF YOUR CARD.***

No Credit Card Option:

☐ I decline to secure a credit card and will pay my balance at the time of service.

Statement Option: (MEDICARE ONLY)

☐ I will receive a statement from Chicago Cosmetic Surgery & Dermatology and remit payment within 30 days of its receipt.

Credit Card Information:

Name of Cardholder: _____ _____
Last Name First Name

Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover ***CHECK IF HSA*** ☐ **HSA cards require an additional card to be secured.*

Credit Card Number: XXXX – XXXX – XXXX -_____ _____ _____ _____ **Expiration Date**: _____ /_____ **CVV:** _____ **Zip Code:** _____

Authorized Signature: _____ **Date**: _____

Name of Cardholder: _____ _____
Last Name First Name

Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number: XXXX – XXXX – XXXX - _____ _____ _____ _____ **Expiration Date**: _____ /_____ **CVV:** _____ **Zip Code:** _____

Authorized Signature: _____ **Date**: _____

I hereby acknowledge receipt of goods and services, and authorize Chicago Cosmetic Surgery & Dermatology and Chicago Skin Science to bill the credit card I have provided above to keep on file for such. I agree to take all further actions required to pay the charges in full and to perform the obligations set forth in my agreement with my credit card issuer. I understand any unpaid balance on my account considered past due is subject to be turned over to a collection agency. I have read, understand and agree to this policy. (Parent or Guardian complete if patient is a minor)

_____ _____ _____
Print Name Signature Date