

## OUR POLICIES

Thank you for entrusting us with your dermatologic care. At Martha E. Stewart, MD, LLC our mission is to provide you with the highest quality service and exceptional care in a comfortable, state of the art environment. Our staff is here to assist you and if you have any questions or concerns please do not hesitate to ask. We ask that you take a few moments to review our policies. Thank you.

**Billing and Insurance:** It is your responsibility to know and understand your insurance plan's policies. There are a number of different insurance plans and each one has its own unique reimbursement procedures. It is your responsibility to notify us of any special requirements in your plan. We accept most insurance plans and will file all claims, including secondary insurance, to the plans with which we participate.

All co-pays and deductibles are collected at the time of service. If you have not met your deductible, we require that you pay a percentage of the contracted fee amount at the time of service. You will receive a bill for the remaining balance. It is important to understand that most insurance companies consider all procedures (ie freezing warts, biopsies, etc.) applicable to your surgery deductible(if you have one). If your insurance company denies your bill, you will be held financially responsible. If you have no insurance or if you are having a cosmetic procedure done, the fees will be collected in full at the time of service. If your insurance changes, it is your responsibility to notify our office at least 24 hours before your appointment to make sure we are a provider. Failure to do so may result in needing to reschedule your appointment and a \$30.00 cancellation fee.

You may receive a separate bill for laboratory/pathology services for any tests Dr. Stewart orders. Please discuss any billing errors or discrepancies with that laboratory.

**Missed Appointments:** If you need to cancel or reschedule an appointment, we kindly request that you give our office 24-hour notice so that we can give that appointment to another patient. If we do not receive 24-hour notice, there may be a \$30.00 cancellation fee billed to the patient or responsible party. Patients who miss their appointment several times, without proper notification, will be discharged from the practice.

**Returned Check Fee/Collections:** There will be a \$35.00 charge for all returned checks. If it is necessary to collect unpaid fees for services rendered, you will be responsible for the charges assessed by the collection service, legal counsel, or court.

**I have read and understand the financial policy of the practice, and I agree bound by its terms.**

\_\_\_\_\_  
**Signature of Patient or responsible Party**

\_\_\_\_\_  
**Date**

Printed Name of Patient \_\_\_\_\_