Dr. Yeoman's Dermatology Office P.C.
1-855-669-2482

Office Policies

Our goal is to provide and maintain a quality physician-patient relationship. To assure you are fully informed in advance of your appointment, we are providing you with our office policies to achieve good communication which enables us to achieve our goal. ***Please read each section carefully and initial***. If you have any questions, do not hesitate to ask a member of our staff.

Appointments

We value the time we have set aside to see and treat you. If you are unable to keep an appointment, we require a 24-hour notice. There is a charge of $50 for a missed clinic appointment and $200 for a missed surgical appointment.

- If you are late for an appointment, it may be necessary to reschedule your appointment.
- We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
- If you “No-Show” for 2 clinic/surgical appointments, you will be dismissed from the practice.

Initials_________

Insurance Plans

- It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
- It is your responsibility to understand your benefit plan: ie. deductible, covered services and participating labs.
- It is your responsibility to know if a written referral or authorization is required to see a specialist, whether preauthorization is required prior to a procedure, and what services are covered.

Initials_________

Financial Responsibility

- You are responsible for any and all co-pays, deductibles and coinsurances as applicable.
- Co-payments are due prior to seeing the provider. If you are unable to furnish your co-pay, you must reschedule your appointment.
- Self-pay patients (see separate policy)
- If we do not participate in your insurance plan, you can choose to pay for your visit in full and we will provide you with a receipt that you can submit to your insurance provider.
- Your patient balance will be billed on receipt of your insurance plan’s explanation of benefits (EOB) and is due 10 business days upon your receipt.

- If previous arrangements have not been made with our office manager, any outstanding balances longer than 60 days will be turned over to our collection agency.
- We accept cash, checks, VISA, Mastercard, Discover credit and debit cards.
- A $25 fee will be charged for any checks returned for insufficient funds.

Initial________

Transfer of Records

- If you transfer to another physician, we will provide a copy of your record and your last visit to your physician free of charge as a courtesy to you. We need 48 hours advanced notice.
- A copy of your complete record is available for the usual and customary rate.

Initials________

Prescription Refills

- For monthly medication refills, we require a 48-hour notice during regular business hours.

Initials________

I have read the above policies regarding my financial responsibility to Dr. Yeoman's Dermatology Office PC. for providing medical services to me or the patient listed below. I certify that the information is correct to the best of my knowledge, accurate and true. I authorize my insurance provider to pay any benefits directly to Dr. Yeoman's Dermatology Office PC., agree to comply and accept the responsibility for any balance that becomes due as outlined previously.

Patient Name (s) ____

Responsible Party Member's Name___________________________________Relationship _____________

Responsible Party Member's Signature________________________________Date___________________

Joint Notice of Privacy Practices
(NPP) Acknowledgement

A joint Notice of Privacy Practice (NPP) is provided to all patients. This NPP identifies:

- How medical information about you may be used or disclosed.
- Your rights to access, amend medical information, request an accounting of disclosures and request additional restrictions on our uses and disclosures of that information.
- Your right to complain if you believe your privacy rights have been violated.
- Our responsibilities for maintaining the privacy of your medical information.

By signing below, I hereby acknowledge I've read the "Notice of Privacy Practices".

Patient/Guarantors Signature____ Date ______________

Employee/Witness Signature____ Date ______________

Patient Name:____ DOB ______________