Allen A. Flood, M.D.
BOARD CERTIFIED
DERMATOLOGY
DISEASES OF THE SKIN, HAIR AND NAILS

FINANCIAL POLICY

As a courtesy to our patients, we submit claims to most insurance companies. Although we do participate with several managed care plans, the balance that your insurance company does not cover is ultimately your responsibility. In order that your claim is processed promptly, it is necessary that we have all pertinent information at the time services are rendered. This information includes a current copy of your insurance card(s) and a valid referral (HMO/POS).

All applicable copays are due at the time of service. We do not charge an additional charge of $5.00 for all copays that are unpaid at the time of service. Our office does not accept checks; copays must be paid using cash or credit card,

New patients without valid health coverage are expected to pay $160.00 at the time of services. This does not apply to patients that have DC Medical Assistance, Medicare, or any HMO, POS or PPO that are currently participating providers.

If your policy (HMO/POS) requires a referral for specialty services, we will make every effort to alert you when a new referral is necessary. IT IS ULTIMATELY YOUR RESPONSIBILITY TO PRESENT A VALID REFERRAL FOR EVERY VISIT, BEFORE YOU ARE SEEN. Please note the number of visits allowed by your PCP and length of time in which your referral will be valid. We will not treat any patient without a valid referral at the time of service.

** As we extend our efforts to set your appointment at a time most convenient to your schedule, we do require 24-hour cancellation. There is a $40.00 charge per missed appointment, when we are not notified within this period. We reserve the right to dismiss any patient from our practice that exceeds a reasonable number of missed appointments in any calendar year.

I HAVE READ AND AGREE TO THE ABOVE POLICIES:

Signature_____ Date _____

AUTHORIZATION OF BENEFITS/RELEASE OF INFORMATION

I hereby authorize direct payment of medical benefits to Allen A. Flood MD for services rendered within his office. I understand that I am financially responsible for any balance not covered by the health insurance policy.

I hereby authorize Allen A. Flood and his agents to release any medical information that is necessary to process a claim for services rendered.

I certify that the insurance information given by me is correct and is valid at the time of service. A photocopy of this assignment shall be valid as the original.

Patient Name (Print) _____

Patient/Guardian Name (Print) _____

Signature _____ Date _____

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