WINDERMERE
Medical Center
Primary Care | Walk-in Care | Chiropractic Care

Patient Financial Policy – Dermatology Services

Our goal at Windermere Medical Center is to provide and maintain an excellent physician-patient relationship. Informing you in advance of our financial policy for Dermatology services allows us to maintain a good flow of communication and run an efficient medical practice.

Windermere Medical Center has a responsibility to provide quality healthcare services to patients. You are being referred for Dermatology services in our office either by the recommendation of your provider, or by a request directly from you.

Your insurance is verified prior to each appointment at Windermere Medical Center. It is also your responsibility to ensure that your insurance is current and that we accept your insurance. If at any time your insurance plan changes, you must notify us immediately.

You will still be responsible for your normal office visit co-pay/co-insurance/deductible fee for your Dermatology appointment. If you have a deductible on your plan that has not been met, the charges for your Dermatology visit *may be applied to this deductible*. Because we do not know what will transpire during your visit (biopsies, surgery, other procedures), we cannot quote you on how much will be charged until after you have been seen. In the case that your Dermatology visit is applied to your deductible, you will receive a bill from Windermere Medical Center for the remaining balance.

Pathology for Dermatology services are *not* billed by Windermere Medical Center. If you receive a bill or explanation of benefits (EOB) from a *pathology laboratory*, please contact our office at 407 876-2273 and ask to speak with our Billing Manager.

<u>No-Show and Cancellation Policy-Dermatology Procedures</u>

If you are scheduled for a dermatology surgery, and you do not show or cancel with less than 24 hours' notice, you will be charged at $50 no-show/cancellation fee.

PATIENT STATEMENT – *Benefit Assignment & Acknowledgement of Financial Responsibility ~*
I understand that I am financially responsible for payment of all non-covered services, co-payments, co-insurance, deductibles, and any other charge(s) my insurance company deems my responsibility. I agree to be responsible for any outstanding balance on my account if charges for my Dermatology visit are applied to my deductible, or if I do not show or cancel an appointment with less than 24 hours' notice.

_____ _____

Print Name **Date**

_____

Signature

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Dermatology History Checklist

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Reason for Visit: _____

Medical History: Check each that applies to you; indicate the age when you had any of the following symptoms or diseases, and mark "C" for current problems.

___ HIV/AIDS	___ CANCER	___ THYROID DISEASE
___ GLAUCOMA	___ DIABETES	___ STROKE
___ ASTHMA	___ SEIZURES	___ TUBERCULOSIS
___ HEART DISEASE	___ ARTHRITIS	___ PSORIASIS
___ PHLEBITIS	___ ECZEMA	___ ABNORMAL MOLES
___ RASH	___ CATARACTS	___ EXCESSIVE SCARRING
___ JAUNDICE	___ HYPERTENSTION	___ ALLERGIES (NON-DRUG)
___ ANEMIA	___ HEPATITIS	___ FREQUENT SUN EXPOSURE
___ PEPTIC ULCER DISEASE		
___ ACTINIC KERATOSIS (PRE-CANCER)		
___ NON-HEALING OR BLEEDING GROWTHS		

OTHER CONDITIONS NOT LISTED:

_____

_____

_____

_____

When you are exposed to sunlight, do you:

___ BURN ___ BURN – TAN ___ TAN ONLY

Allergies to medications: _____

_____

History of skin cancer:

___ BASAL CELL ___ SQUAMOUS CELL ___ MELANOMA

Type of treatment: _____

_____

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www.WindermereMedicalCenter.com