Shady Grove Dermatology, LLC
JOSEF K. YEAGER, M.D., SANDERS H. BERK, M.D., THOMAS M. KEAHEY, M.D., CAROLINE E. YEAGER, M.D.

Financial Policy

Shady Grove Dermatology, LLC participates with many of the area's health insurance plans. Patients are expected to bring their insurance cards with them to every appointment and inform our office of any address, telephone number or other demographic changes. All copays are due at the time of service. It is important to note that just because Shady Grove Dermatology, LLC participates with your insurance company does not guarantee that the services will be paid in full. Payment depends on the benefits of your specific insurance plan. If your insurance plan requires you to have a referral, please bring the referral to your visit. If you do not have a referral at the time of your visit, you may be responsible for payment. In order to understand the full impact of your financial responsibility, it is important that you, as the patient, contact your health insurance carrier to verify that your care will be covered.

All balances are due in full within 30 days of the statement date. If you are not able to pay the balance in full, please contact our billing office at 240-246-7417 to set up a payment plan. We accept Mastercard, Visa, cash and checks. If a check is returned and the bank charges the office a fee, that fee will be passed on to the patient.

Laboratory Fees-If your visit requires us to utilize a dermatopathology laboratory, depending on your coverage, you may receive a bill from that laboratory. The laboratory is separate from Shady Grove Dermatology, LLC and has no affiliation.

Self-Pay Patients-All self-pay patients are expected to pay the balance in full when the services are rendered.

Patients are encouraged to give their physician 48 hours notice when possible when cancelling an appointment. Patients who repeatedly fail to present for an appointment without calling may be discharged from the practice.

Patients who fail to present for an appointment or cancel within 24 hours may be charged a fee of $25.00 for missed appointments or $100 for missed surgery appointments. Patients requesting letters or forms completion by the physician may be charged a fee of $25.00.

I hereby assign all medical and surgical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to Shady Grove Dermatology, LLC. for medical services rendered. I understand that I am responsible for any amount not covered by insurance.

_____ _____

Patient Signature or Responsible Party Date

_____

Patient Name (printed)

15245 SHADY GROVE ROAD, SUITE 370, ROCKVILLE, MARYLAND 20850
PHONE 240-246-7417 FAX 240-246-7444