

# COSMETIC SURGERY & DERMATOLOGY OF ISSAQUAH, INC.

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## Financial Policy

We at Cosmetic Surgery & Dermatology of Issaquah, Inc. are committed to providing the highest level of quality medical care and personal service to our patients. We ask that the patient or guardians' take responsibility to meet their financial obligations. We see patients from many different insurance plans and it is impossible for us to know all the covered benefits, co-pays and deductibles for each plan. In addition, your insurance company will not guarantee payment to us even though we do preauthorize procedures. While it is our intention to assist, it is still your responsibility to ensure that all services rendered are paid in full. In order to clarify, our requirements are listed below:

### **Appointments**

As a courtesy, 24 hours notice is expected if you need to cancel or reschedule your appointment. Missed appointments without notification may not be able to be rescheduled.

### **Financial Responsibility**

You, the patient (or the patient's guarantor), are ultimately responsible for all charges associated with your care regardless of insurance coverage. Co-payments and Deductibles are a contract responsibility between the patient and their insurance. These amounts are non-negotiable.

### **Patients Without Insurance Coverage**

Payment at the time of service is required.

### **Participating Insurances**

We participate with a variety of insurance plans. It is your responsibility to:

- Verify with your insurance that we are a contracted provider
- Bring your insurance card and picture ID to every visit
- Be prepared to pay your co-pay before each visit
- Bring any required referral for treatment prior to or at the time of your visit

### **Pre-Surgery/Pre-payment**

Your insurance carrier will be contacted to verify benefits and eligibility prior to surgery. We will also assist you in estimating your costs. Pre-payment of deductibles will be required.

### **Additional Charges**

- For checks returned for Non Sufficient Funds, a \$55.00 fee will be charged to your account.
- A service fee of \$10.00 will be charged monthly on all balances not paid in full after 45 days. If payment arrangements have been made and arrangements are not being honored your account will be turned over to our Collection Agency.

### **Collection Accounts**

If your account is sent to collections, you will need to contact our collection agency. Medication refills and future appointments will not be made if account balances are not current.

Physicians & Dentists Credit Bureau, 12710 Gateway Dr. Suite 206  
Seattle, WA 98168 Phone: 206-624-1661 Fax: 206-624-0258

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**Patient's Signature**

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**Witness**

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**Date**