Boulevard Dermatology
8001 Roosevelt Blvd Ste 307
Philadelphia, PA 19152

Financial Policy

We appreciate the opportunity to serve you, and want to thank you for choosing our clinic for your Dermatology services. We are committed to your treatment success and strive for providing you excellence in service. Prior to receiving any services, we do require you to read and sign the following statement regarding our Financial Policy:

Forms of Payment We accept cash, check, Visa, MasterCard, Discover, AMEX and CareCredit.

Patient Responsible Balances Due at Time of Service Co-pays that are required by your insurance policy are due at the time of service. If you have no insurance and are self-pay, or if having an elective non-covered service, your balance in full is required at time of service. If you or any of your family members have an outstanding balance, we may ask for payment of this balance at this time.

Insurance Billing As a courtesy to our patients, we bill most major insurance carriers directly. Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. You are responsible for understanding how your insurance works. If your insurance denies a claim due to inaccurate or incomplete information you have provided to either us or them, we may bill you directly for the unpaid balances. We are not obligated to wait for you to resolve a dispute with your insurance company before seeking payment from you. We will ordinarily help you as best as possible to get proper and timely payment from your insurance.

Minor Patients A parent or legal guardian must accompany minors at EVERY visit, this person becomes the responsible party. Unaccompanied minors will have to reschedule to a date a parent can attend. If parents are separated or divorced, accurate parent and insurance information is required at the time of service, and only with written consent can any parent become the responsible party. In the event of any disputes, the parent or guardian who accompanied the minor at the initial visit bears responsibility for outstanding balances.

Missed Appointment Fees If you miss, cancel or reschedule an appointment within less than 24 hours of the appointment time, there may be a $35 fee assessed to your account, depending on the circumstances and previous appointment history. Missed surgery appointment: We need 48-hour notice to change a surgery appointment or a fee of $100 will be assessed.

Cosmetic Cancelation Fees We require 24 hours' notice for the cancelation of any cosmetic procedure, failure to comply will result in the charge of a $100 fee.

Returned Check Fees If your check is returned by the bank due to insufficient funds in your account, there will be a $36 fee assessed to your account.

Account Balances Please pay your bill promptly or call us at your earliest convenience if you have any questions about your balances due. Our general policy is that balances due be paid within 30 days. Outstanding balances not paid within 90 days may be turned over to a collection agency, resulting in further finance charges and reporting to national credit bureaus, such as Trans Union, Experian and Equifax. Please contact us immediately if special financial circumstances arise, as we may be able to arrange a payment plan.
Thank you for taking the time to read and understanding our Financial Policy. Please let us know if you have any questions or concerns.

Telephone Consumer Protection Act (TCPA)
You agree, in order for us to service your account or to collect monies you may owe, **BOULEVARD DERMATOLOGY**, and/or our agents may contact you by telephone or any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/we have read this disclosure and agree that **BOULEVARD DERMATOLOGY**, its employees and/or agents may contact me/us as described above.

My signature below indicates that I have read, understand and agree to the terms of this Financial Policy:

_____ _____
Signature of Patient or Responsible Party **Date**

_____
Printed Name

Patient Name (Print):_____ DOB: _____

Legal guardian Name (Print); _____