SUNFLOWER
DERMATOLOGY & MEDICAL DAY SPA
better skin for a better life®

Patient ID_____

Provider_____

FINANCIAL AGREEMENT:

- All contracted insurance are billed directly to your insurance company as a courtesy of Sunflower Dermatology and Medical Day Spa LLC (SFD). Any remaining balances for non-covered benefits deductibles, copays and coinsurances are your responsibility. These may be collected prior to any potential procedure. **It may take up to three months or longer for your insurance to process your claim.** Therefore, the charge to your credit/debit card may be delayed.
- We require a copy of a valid credit or debit card to be kept on file. You will not receive a bill but will receive an EOB (explanation of benefits) from your insurance company explaining costs incurred. Monies due to SFD based on your EOB, will be charged to the card on file upon our receipt of the EOB**.**
- **_____Please initial acknowledging the above statement.**
- There is a $30 fee for all returned checks.
- Out of respect for all patients waiting to see the doctor, there will be a $75 fee for no showing to appointments.
- All accounts that become past due 45 days after your insurance pays, we reserve the right to send your account to a collection agency if the balance is not paid in full within 60 days.
- For all skin lesion removals (i.e. cosmetic or medical), a skin specimen is sent to the pathology lab for testing and to confirm clinical diagnosis. There may be additional charge by the lab, unrelated to any fee paid directly to Sunflower Dermatology and Medical Day Spa, LLC
- A copy of this form will be available at your request.
- I authorize the release of medical information to my primary care or referring physicians, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.
- I hereby acknowledge that I have read, understand and agree with the policies set forth by Sunflower Dermatology & Medical Day Spas LLC and any change made by me will be made only in writing. I give my authorization for the charge of my valid debit/credit card and my consent for procedures as outlined above.

I consent to the financial agreement above.

_____	_____	_____
Name of patient	**Signature of patient**	**Date**
_____	_____	_____
Name of parent/guardian	**Signature of parent/guardian**	**Date**

Reviewed by:_____(Physician Signature)