Patient Financial Policy
(Revised 1/2026)

Welcome to Carlisle Dermatology Group, LLC. We are dedicated to providing you with the highest level of medical care in a compassionate and proficient manner. All patients are expected to sign and comply with our patient responsibility form annually. Please carefully read the Financial Policies described below.

Your co-payment will be collected on the date of service. Any deductible, co-insurance, or payment for non-covered services is due in full at the time services are rendered. We cannot waive a co-payment, deductible, co-insurance service or non-covered service amounts defined as patient responsibility under the terms of our contract with various health plans. For your convenience we accept cash, personal checks, and most major credit and debit cards as payment options.

It is your obligation to make certain that our office is a participating provider with your insurance and that referral and/or prior authorization is obtained in advance. We will file your insurance claim for you if all necessary information is received at the time of your appointment. It is also your responsibility to inform our office of changes in insurance coverage and/or personal contact information. Non-emergency treatment will be denied unless non-covered charges and copays have been paid and insurance billing is approved under the insured's policy. We do not bill preventative service codes. Dermatology is a "problem orientated" specialty and we only address and treat one body system "the skin", therefore we do not meet the criteria required to bill preventative codes.

If payment is not received from your insurance within 90 days, you will be billed for services rendered. You will also be billed for any services not covered by your insurance company. An account for which no payment is received within 90 days and for which no payment arrangements are made may be sent to a collection agency. The balance will include an additional 33.33% fee for the expenses related to collections. Any future appointments will be cancelled, and your account will be rendered inactive until payment is received in full. Checks returned to our office for non-sufficient funds (NSF) will incur a $30.00 service charge.

Additionally,

*****Patients are seen by appointment. If you cannot keep your appointment, it is your responsibility to call at least 24 hours in advance. We understand that occasionally it will be necessary to change or cancel an appointment in less than 24 hours; however, a fee may be assessed for cancellation within 24 hours and/or for a No Show. Families of 3 or more, who missed their same day scheduled appointment and fail to provide a minimum of 24-hour notice, will incur a $250.00 fee.**

*****Surgery, unlike office visit appointments, requires 10 business day notice for cancellation. If a Mohs surgical procedure is cancelled within 10 business days, you will be assessed a cancellation fee of $200.00. If a surgical procedure is cancelled within 10 business days, you will be assessed a cancellation fee of $100.00.**

When skin growths are biopsied or removed, there are two separate charges. The first being a charge for the actual biopsy/removal performed. The second being a lab charge for review of specimen by a Dermapathologist. If the specimen slides require a second opinion or special stain, an independent lab (not owned by our practice) will bill your insurance carrier for the additional fees. If you have questions about these additional fees, please contact the lab directly as these fees are not charged by our office.

Unaccompanied minors must have consent signed by a parent or guardian to be seen without a documented responsible party. Copays and other charges need to be paid prior to the patient being seen, these charges can be paid via telephone by credit/debit card if needed.

Should you request copies of your medical records, there is a fee charge as allowed by Pennsylvania statues. There is also a cost associated with your request for physician "narrative reports" and/or letters not related to our insurance claims. These fees would be based on the complexity and the amount of time involved.

Our staff will be happy to answer any questions you may have about our policies.

I have read and understand the terms of this financial policy. I understand and agree that such terms may be amended from time to time by the practice. I agree to assign insurance benefits to Carlisle Dermatology Group, LLC. I authorize the release of my medical information to my primary care, referring physician, and/ or consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

Signature of Responsible Party: _____ Date: _____

Name of Patient: _____ DOB: _____