MID-COUNTY
DERMATOLOGY

Financial Obligation Agreement

3009 N. Ballas Road, Building B, Suite 208
St. Louis, MO 63131
314-994-0200

Patient Name: _____ Date of Birth: _____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my medical visits. This includes any medical service, visit, preventative exam or physical exam, lab test, imaging test, pathology test, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the physician or the physicians' staff to know if my insurance will pay for any medical service I receive.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, coinsurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the medical services I receive. If I have an insurance plan with a deductible or co-insurance responsibility, I agree to pay this fee at the time of my visit. After receiving my billing statement, I agree to pay for my patient-responsible amount that was not fully covered by my insurance. I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible for all charges. I understand and agree it is my responsibility to know if a referral is needed to see a specialist. I understand this and agree to be financially responsible and make full payment.

I understand and agree that if I am unable to keep my appointment, then I must notify the office at least 24 hours in advance of my appointment time. This is necessary to accommodate another patient waiting for an appointment time that would otherwise not be available. I will be reminded of my appointment by phone 24-48 hours in advance. I will respond and notify the office by phone if I can not keep the appointment.

Print Name: _____ Date: _____
(patient/parent/conservator/guardian)

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

Responsible Party Name: _____
(please print name of Responsible Party if different from Patient)