**ADVANCED DERMATOLOGY ASSOCIATES OF SUSSEX COUNTY, P.C.**

**ACKNOWLEDGMENT OF SELF–PAY STATUS PATIENT RESPONSIBILITY**

**Dear Patient,**

**You are being provided this letter of acknowledgement because you have requested that your doctor visit today be coded as “self-pay” and that you receive a “self-pay discount.” A self-pay discount is offered to patients who elect to pay for the service in full on the date of service and acknowledge that Advanced Dermatology will not be submitting the claim to an insurance carrier. You have requested that this service be coded as self-pay because (initial one):**

**\_\_\_\_ You have no health insurance.**

**\_\_\_\_ You have health insurance, but you do not want your insurance billed and instead want to pay out of pocket.**

**\_\_\_\_ Advanced Dermatology does not participate with my insurance.**

**\_\_\_\_ Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below you agree to the following:**

* **All fees for the self-pay service must be paid on the date of service.**
* **The self-pay amount covers *only* the professional services provided by your physician. You are financially responsible for all ancillary services, for example laboratory, pathology or other services not performed by your physician. You may receive a separate bill from those non-physician services.**
* **If you have insurance or other types of coverage, services received today that are included in the “self-pay” discount will not likely be reimbursed by your carrier or applied to your deductible. You may want to discuss this with your insurance carrier before agreeing to the self-pay discount.**
* **Advanced Dermatology will not submit billing to your insurance carrier for previously completed self-pay visits if you choose to revoke your self-pay status at a later date.**
* **If more than three years passes between office visits, you or your dependent will be treated as a new patient upon your return. A higher initial office visit fee will be charged for this visit to reestablish you as a patient.**

**By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient’s duly authorized representative.**

**Patient Name (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guardian Name (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**