Melanie R. Haynes, M.D. ● 9005 Belcher Road ● Pinellas Park, FL 33782
Office: (727) 545-3376 Fax: (727) 545-5003

Dear Valued Patient,
Please note our policies listed below and sign this form as acknowledgement.

*Patient Owed Balances

After collecting your copay and/or estimated deductible, your claim will be submitted to your insurance company (and secondary). Once we have received final payment from your insurance company, a bill will be mailed to you for the remaining patient-owed portion. These balances are usually for unpaid copayments, non-met deductibles, or non-covered services per your plan's benefits. You may still have claims that are being processed for other dates of service that have not been reconciled.

This office will send *only two statements*. The statements are sent at 20-day intervals. If no payment is received on your account during the 40-day period, your account will be turned over to collections, incurring a $10.00 collection fee, *without additional notice*. We feel that two billing cycles is a reasonable amount of time to make payment on your account.

For your convenience, accounts can be paid using your credit card by calling our office at 727-545-3376. Or you can indicate your credit card information on the statement and mail it.

* FDA Office Prescribing Service

Skin Wellness Center is both pleased and proud to announce that we have taken a critical step in advancing the QUALITY and AFFORDABILITY of your care! We have partnered with an FDA-approved facility in order to provide customized pharmaceutical prescription medications.
THIS ADVANCEMENT ENABLES US TO:

** Dispense at the time of your visit*
** Offer quality medications usually LESS THAN YOUR INSURANCE CO-PAY*
** Minimize insurance denials of medications*

As always, YOU HAVE THE FREEDOM TO CHOOSE! *Please tell us if you prefer to receive commercially available medications from a pharmacy*.

*Charge for No-Show, Cancellation less than 24 hours

Please read the new policy on the laminated form explaining incremental charges and ultimately dismissal from the practice for repeated occurrences. Our goal is to provide quality care to our patients and use our scheduling time efficiently to accommodate all of our patients.

**Your signature on this form acknowledges that you have read and understand the policies listed above. It is our pleasure to provide the best service to our patients. We thank you for choosing Skin Wellness Center for your dermatologic care.*

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Date Signature of patient