LIMMER DERMATOLOGY
Your Skin. Our Specialty.

14615 San Pedro Ave. Ste. 210
San Antonio, TX 78232
Phone: 210496-9929
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FINANCIAL RESPONSIBILITY FOR MEDICAL SERVICES

You are responsible for deductibles, co-payments, coinsurance amounts or any other patient responsibilities indicated by your insurance carrier or our FINANCIAL POLICIES. _____
Initial

☐ **Medicare and Secondary Insurance** coverage will be filed with both policies and billed according to Medicare guidelines. _____
Initial

☐ **Self Pay** (this applies to all non-Medicare insured patients and all uninsured patients). I am aware that I am responsible for payment in full._____
Initial

☐ **Medicare Part A (Hospital) benefits ONLY**. I am aware that I am responsible for payment in full.
_____
Initial

☐ **Medicare PPO Replacement** and will be billed according to Medicare guidelines. Copay amount today is $ _____. _____
Initial

☐ **Medicare Part B benefits ONLY**. I am aware that 20% of my visit is due at the time of service._____
Initial

☐ **Medicare age** but I **DO NOT** have Medicare or a Medicare Replacement. I am aware that I am responsible for payment in full. _____
Initial

HMO Medicare Replacement, we are considered to be out of network but will only bill you Medicare rates.

☐ **I am aware and understand that Limmer Dermatology are not providers with any HMO insurance companies and I am responsible for payment in full at the time of service.** _____
Initial

We will file your insurance for the **Mohs procedure**. However, we will be considered **out-of-network** with all insurances (except Medicare) and you will be responsible for the balance not covered.

- It is our pleasure to contact your insurance company to get a quote of benefits and to determine your responsibility.

I hereby authorize Limmer Dermatology to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow the signature below to be used on all insurance claims.

Payment Policy

Any co-payments, previous balances, or any procedures not covered by insurance are due at the time of service. You will be given a receipt to use when filing a claim with your insurance company. Many insurance companies will pay the patient directly for the claims we submit. In the event this happens, it is your responsibility to get the payment to us.

- We accept cash, check, Visa, and MasterCard for all payments.
- We do not accept post dated checks.

PLEASE NOTE: There will be a $35.00 collection charge for checks that are not honored by your bank.

_____

(Print Name) Patient or Responsible Party (Signature) (Date)