Bella Dermatology & Medical Spa

Terry L. Sharpe, M.D.

2340 Patrick Henry Pkwy., Ste. 200

McDonough, GA, 30253

770-507-8481 phone

770-507-5358 fax

Insurance:

Our office will file your insurance claim to your insurance company as a courtesy. Co-payments are due at the time of sign in for each office visit and payable by Master Card, Visa, Discover, or cash. We do not accept American Express or checks in our office. Co-insurance (patient's responsible percentage) is due at the time of sign in for each office visit. You are responsible for any services that your insurance company deems as not medically necessary, does not cover, or does not pay within 30 days from the date of service, which is due and payable before services are rendered. You are responsible for your account with our office, not your insurance company.

Missed Appointments:

There will be a **$145.00 fee** charged for all office visits and all surgery appointments that are **not** canceled within 24 hours. There will be a $45.00 service fee for appointments canceled/rescheduled the day of your appointment and a $75.00 service fee for surgical procedures canceled/rescheduled the day of your appointment. Our office will not schedule any appointments until the balance is paid in full. Upon two missed appointments, our office will refer you out of our practice.

Delinquent Accounts:

Any account not paid in full after 30 days will be charged interest at the rate of 1.8% per month. If your account is referred for collections, a fee of 35% will be added, and you will be held responsible for any filing charges, lawyer fees, court costs, postage charges or other intangible fees related to the collections process.

Documents and Forms:

There will be a $25.00 charge for any forms or documents that need to be filled out. These fees will be collected before they are filled out.

Prior Authorizations:

The doctor prescribes what she feels is best for your treatment. Any prior authorizations of medication will require a $50.00 charge. These fees will be collected before the authorization is done.

Patient's Name_____

Patient's or Guardian's Signature_____

Date_____