Andrea Trowers M.D., P.A

EASY PAY CONSENT FORM

Areas highlighted in yellow are required to be completed in the office.

If we are a participating provider for your health insurance, we will file insurance claims to your company. **We do not verify insurance plan coverage & benefits. Prior to your appointment we suggest you call member services to confirm network participation.** If a service performed by the doctor is denied, not a covered service or you are found to have a deductible or co-insurance amount, you will be responsible for paying the balance with the Easy Pay Form. **You have the option of filling out the Easy Pay Form, paying cash for the visit, providing a blank check made out to Dr. Andrea Trowers or being referred to another dermatologist.** The validity of the credit card will be checked prior to services being rendered.

What is the Easy Pay Form? Why is it necessary?
Occasionally you will have deductibles & co-insurance obligations unbeknownst to us that have been set by your insurance company, leaving a balance on your bill. We will always warn you if we feel a service may not be covered, however, ultimately the insurance contract is between you & your insurance company.

Your insurance will mail you a notice of your balance. If we receive notice from your insurance company that there is a balance on your account your payment will be processed with the Easy Pay Form. **Andrea Trowers MD PA does not mail invoices or bills to patients for balances.** This allows us to obtain quick payment so that we may concentrate on providing you with quality medical care and not be occupied with sending outstanding balances to collection agencies.

Please complete the square below to authorize future payment for any balance which will be an out-of-pocket expense, **as determined by your insurance company only**. Your information will be kept in a PCI compliant system. Once entered in the system, all numbers are encrypted and only the last 4 numbers as visible to us.

I authorize ANDREA TROWERS MD PA to keep my signature on file and to charge my credit card for the patient responsibility portion of any balances incurred by me. I understand that I am entitled to a refund should my insurance company later decide to pay for the service initially denied.

I understand that this EASY PAY system will only be implemented in the following cases:
- If a deductible has been applied by my insurance company.
- If I am not covered by my insurance for the services rendered.
- If a service that has been provided is not covered by my insurance company.
- If I fail to cancel 24 hours prior to a follow-up appointment I may be charged a no-show fee.
- If I fail to cancel 48 hours prior to a surgery I may be charged a no-show fee.
- If I fail to cancel **48 hours** prior to a facial appointment my reservation fee is not transferrable & will not be refunded.

PATIENT NAME _____ **DATE OF BIRTH** _____

In the boxes provided please enter the last 4 digits of the credit card you agree to keep on file.
Please present card for verification.

X	X	X	X	X	X	X	X	X	X	X	X				

Expiration Date: _____ **Type:** Visa Mastercard American Express Discover

Billing Address: _____

Name on Card: _____ **Cardholder's Signature:** _____ **Date:** _____

If it is determined that you are due a refund, the fastest way to receive the refund is via Zelle.

Please clearly write the name, email address or phone number linked to your registered Zelle account.

NAME _____ **EMAIL ADDRESS / PHONE NUMBER** _____

I acknowledge that I have read and fully understand this consent form.
I am prepared to complete this required form upon check in at the office.