

**Trident Dermatology**  
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**Patient Financial Policy**

Trident Dermatology requires that you pay your financial responsibility at the time services are rendered.

Trident Dermatology will gladly file your insurance claim for you. We do ask that you provide us with the necessary information to do this. We will need a copy of your insurance card to be sure we have the correct insurance billing information. If a billing problem arises, we may ask you to provide (verify) additional information concerning your coverage. It is the responsibility of the patient to notify Trident Dermatology of any changes in coverage. **WE MUST OBTAIN AN UPDATED PATIENT INFORMATION FORM WITH A SIGNATURE EVERY 6-12 MONTHS.**

For patients with insurance plans for which we are a contracted provider, the appropriate co-pay, deductible, co-insurance, and charges for any non-covered services will be collected at the time of service.

For patients who are covered by insurance plans in which our physicians are not contracted providers, you will be required to pay 50% of the charges at the time of the service. After we file the claim and receive payment, you will be billed for any unpaid charges regardless of the benefits and payment policies of the plan.

For Self Pay and patients having a service provided that is not covered by insurance, all charges will be collected at the time of service.

For elective cosmetic procedures, payment is due 5 business days prior to the procedure. We accept Cash, Check, VISA,

MasterCard, Discover, Money Order and CareCredit®.

**Charges and fees are as follows:** A \$50 no show fee will be charged for surgery and procedures. A \$25 no show fee will be charged for regular office visits. A surgery deposit will be required to schedule depending on your insurance policy coverage. Surgery cancellations must be called in at least 48 hours before the scheduled time or a \$50 fee will be charged to the patients account.

**AN IMPORTANT WORD ABOUT LAB TESTS AND BIOPSIES**

In order to accommodate all of our patients, we participate in many insurance plans that may require the use of a specific lab. **Please tell us if your insurance company requires that your lab work be sent to a specific lab.** Otherwise, you will be responsible for the charges incurred if the lab work is sent to an "out of network" lab.

Please be aware that you will receive a separate bill from the lab for any lab work that is obtained by our office and sent to them for testing. We will provide them with your insurance information.

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Patient Signature

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Date