

**Patient Name** \_\_\_\_\_ **Chart#** \_\_\_\_\_

## **Atlantic Shore Dermatology Payment Policy**

**Atlantic Shore Dermatology has applied to be a participating provider with most Insurance Companies in this area, but at this time some contracts are still pending. Your Insurance Company may process your claim under out of network benefits. This means you may have a separate out of network deductible amount due after your Insurance processes your claim.**

**As a courtesy, Atlantic Shore Dermatology will bill most insurance for medical services provided.**

**We apologize for any inconvenience this may cause.**

\_\_\_\_\_  
**Signature of patient/Guardian**

\_\_\_\_\_  
**Date**