

# DERMATOLOGY CENTER OF ROCKLAND, PC

Thank you for choosing our practice. We provide the best dermatological care for you, and we want you to completely understand our financial and cancellation policies.

## **CANCELLATION OF APPOINTMENT**

Your appointment time has been reserved especially for you. If you do not show or cannot keep your appointment, **please call at least 24 hours prior to your appointment time**, or a fee of \$50.00\* will be charged to your account. For cosmetic appointments, if you do not show or **cancel within 48 hours prior to your appointment** a fee of \$100.00\* will be charged to your account. You will be personally responsible for this charge. It is not covered by your insurance plan. Future appointments will not be scheduled until this fee is paid.

## **FINANCIAL and ELIGABILITY POLICY**

The patient or patient's legal representative hereby certifies that he/she is eligible for healthcare benefits coverage and has chosen Dermatology Center of Rockland, PC providers for his/her health care.

The patient or patient's legal representative understands he/she is responsible for any co-pay and/or deductible and if a patient is found ineligible for coverage of plan benefits, he/she is financially responsible for all costs and expenses incurred during the delivery of health services and agrees to pay these charges to the physician accordingly.

Payment for service is due in full at the time of service. We accept cash, personal checks, Apple Pay and credit cards.

It is the patient's responsibility to notify us immediately of any changes in their insurance coverage or carriers. The best way we can facilitate this is for you to bring your insurance card(s) with you for each visit. We apologize if this presents any inconvenience. Please understand that it is ultimately the patient's responsibility for payment of services. If your insurance company or other benefits program (HMO, PPO, or managed care) does not cover the entire balance, you are responsible for the remaining amount, annual deductible, co-payment and coinsurance. It is the patient's responsibility to bring a valid referral for each visit, or you will be asked to reschedule your appointment or sign a waiver and pay privately for your visit.

Please be aware that some services provided may be determined as "non-covered" services under your policy. It is the patient's responsibility to be aware of the individual policy restrictions and guidelines. Payment is due at the time of service, or within 30 days upon receipt of a statement from our office.

**Medicare:** Patients are responsible for meeting their annual deductible and paying 20% co-insurance.

**Note:** If you have recently joined (or changed) to a Medicare HMO/PPO, please let our staff know so we can update your records and advise you if we are participating providers.

**Note:** Dermatology Center of Rockland, P.C. will only file secondary insurance if you have Medicare. We can supply you with any information that you may need to file with your secondary insurance company for reimbursement.

If a check is returned to the office for any reason, the original check amount plus a \$35.00\* returned check fee must be received within 30 days from the date the check was returned to avoid further late fees or collection action.

Please be advised any patients requiring biopsies and/or cultures sent to an out of office Laboratory, will be billed separately from that facility. I authorize Dermatology Center of Rockland to release any medical/insurance information necessary to process the claim. I understand I will be responsible for any co-pay, coinsurance, deductible etc. that is owed to this facility.

I reviewed and understood your policies and my responsibility regarding charges incurred in this office.

Signature: \_\_\_\_\_

(Patient)

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

(Guardian or Responsible Party)

Relationship: \_\_\_\_\_