Siperstein Dermatology Group

Office Policies and Assignment of Benefits

YOU ARE RESPONSIBLE FOR YOUR INSURANCE POLICY

Due to the many changes in insurance policies, we cannot be responsible for interpreting each individual policy. **It is the responsibility of the patient to understand their individual coverage and its limitations, as well as the providers accepted by the plan.** We urge you to check with your insurance company regarding your benefits because failure to comply could result in you, the patient, being responsible for all costs incurred.

Insurance Policies are a contract between the patient and the carrier. It is the responsibility of the patient to know which providers are in their specific network.

Financial Responsibility: Patients are financially responsible for all charges, whether paid by their insurance for all services rendered on their behalf or dependent's behalf.

Payment: Any and all co-pays, co-insurance, deductibles and account balances are due at the time of service.

Balances: Balances outstanding for more than 90 days will be subject to collection fees (*at the patient's expense)* and may be referred to a collection agency.

Referral/Authorizations: If the patient's health insurance policy requires a referral/authorization, it is the patient's responsibility to obtain it prior to the scheduled appointment. Since most insurances will deny wellness visits for Dermatologists, we do not offer this service.

Return Policy: Any defective product or any product that has caused an allergic reaction which has been documented by a physician, may be returned within 30 days. Prescription strength products are non-returnable.

Appointment No Show / Cancellation Policy: We require a 24-48 hour cancellation notice. A $50 fee will be charged for all medical appointments and $100 for any surgical appointment that is cancelled without providing proper notice. Cosmetic appointments will require a deposit of $50-$200 depending on the type of the appointment, and this deposit amount will be charged as a fee if the appointment is cancelled with less than 24-48 hours' notice. These fees can be waived at the discretion of the billing office, one time only, if there is an emergency (hospitalization, accident, etc.…).

Lab Fees: Please be advised that all specimens (biopsy, cultures, etc) will be sent to an independent Lab to be processed and you will receive a separate bill from that lab. ____

Returned Check Policy: A fee of $50 will be charged for each check that is returned (subject to change).I certify that all the insurance information that I have provided is current and correct. I authorize Siperstein Dermatology Group to administer medical care as deemed necessary. I authorize the release of any medical information requested by my insurance carrier in order to process insurance claims. I understand that I am personally responsible for all fees, including deductibles, co-pays and co-insurance incurred for services rendered to me or a dependent. I authorize payment of insurance benefits paid on my behalf, to be made directly to Siperstein Dermatology Group. I authorize Siperstein Dermatology to release medical information to a 3rd party or its agents.

I certify that I have read this form in its entirety and will abide by the above policies.

Print Patient Name:_____ DOB:_____Date: _____

Patient's Signature (*or Other Legally Authorized Person's)* _____