



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) _____