Garden City Dermatology
901 Stewart Avenue, Suite 201, Garden City, New York 11530
[P] 516-227-3377 [F] 516-227-3378

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE PROVIDER. WE WILL REQUIRE A PHOTOCOPY OF YOUR INSURANCE CARD(S) AND PICTURE I.D. FOR YOUR FILE.

- **APPOINTMENTS –** 24-hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice; a cancellation fee of $25.00 may then be added to your account. If you do not show for two or more appointments, without 24 hours cancellation notice, you will be required to leave a $25.00 deposit for all future appointments.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is your responsibility to obtain it prior to your appointment. If you do not have your referral you will be required to pay for your visit or reschedule at a later date.

- **CO-PAYMENTS** – By law, we MUST collect your carrier-designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, a billing fee of $20.00 may be added to your account, if payment is not received within two billing periods, approximately a 60 day period.

- **FEES –** A $20 billing fee may be added to any balance due to this office, if payment is not received within two statement periods, approximately a 60 day period. If an outside agency is required to collect any balance due to this office, you will be held responsible for your original balance, any and all $20 billing fees and 1.5% monthly interest. This 1.5 % interest will begin to accrue at 60 days from the initial statement.

- **DEPOSITS** – If your appointment requires more than one time slot you must pay a $25.00 deposit.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service.

- **MEDICARE** – We will submit claims to Medicare. You will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Garden City Dermatology for any services furnished to me. I authorize any holder of medical information about me to release to Garden City Dermatology (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims and benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The parent who consented to the treatment of a minor child is responsible for payment of any fees not paid by the child's insurance carrier. Garden City Dermatology will not be involved with separation or divorce disputes.

You are responsible for timely payment of your account. Should it become necessary for us to use an outside agency to collect payment for you, you will be additionally responsible for whatever charges we incur as a result of this. I agree to pay all monies, including the full original fee, all $20 billing fees and 1.5% monthly interest so that City Dermatology receives full reimbursement of monies due. I understand I am responsible for any and all services not covered by my insurance company. I accept responsibility for payment of my account.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS OR DISCOVER CARDS.

Printed Patient's Name: _____ DOB: _____/_____/_____

Patient Signature:_____ Date: _____

If patient is under 18, Parent or Guardian must also sign below:

Responsible Party Printed Name: _____Realtionship:_____

Responsible Party Signature: _____ Date::_____ _____

Garden City Dermatology

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Welcome to Garden City Dermatology. We have recently implemented a new payment policy that aims to make paying Co- insurance and deductible balances fast and simple. You will be asked for a credit card number at the time you check in, this information will be held securely until your insurance carrier has paid their portion and notified us of the amount of your share. At that time, any remaining balance owed will be charged to your credit card, and a copy of the charge will be mailed to you. If you have any questions please call our Practice Administrator at 516-227-3377.

ALL Co-pays will still be collected at the time of your visit.

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I authorize Garden City Dermatology to charge outstanding balances on my account to the following credit cards:

Visa Mastercard American Express Disc Other:

Credit Card # _____

Expiration Date: _____ CVC#_____

Name on card (Please Print) _____

Name of Patient (Please Print) _____ Patient Acct#_____

Signature _____ Date_____