THE DERMATOLOGY CLINIC

Office Policies

Patient Name: _____

We are committed to meeting your healthcare needs. Our goal is to keep your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank will result in a **$25.00 return check charge** being added to your account.
2. Please provide us with your current address, telephone number, and insurance information. You may be asked to update this information yearly.
3. It is your responsibility to contact your insurance carrier to confirm that our provider participates in your plan. If your see one of our providers who is not on your insurance plan, you will be responsible for payment in full.
4. If your insurance plan requires a **REFERRAL**, it is your responsibility to obtain it prior to being seen by our provider.
5. Your co-pay is due at **EVERY** visit prior to be being seen by our providers. There are no exceptions to this policy. If there are additional charges such as deductibles, co-insurance payments, or other services these will be collected upon check-out. Please be prepared to pay for these services at the time they are rendered. There is a billing charge of $25.00 for unpaid deductibles, co-insurances, or co-pays. We realize that co-pays, co-insurances, deductibles can add up especially if you have a large deductible. Please direct any questions on this matter to your insurance company.
6. Please secure your personal items and other valuables when you visit our office. We cannot be held liable for lost, broken, or stolen items.
7. We would appreciate a 48 hour notice if you are unable to keep your appointment. This allows us to offer this time to another patient who needs to be seen. If you do not give 48 hour notice a charge of $25.00 will be applied to your account.
8. All medical record requests must be in writing and received in advance. There will be a $1.00 per sheet charge for printing all medical records. Additional charges for mailing records will apply.
9. In the event the balance on your account become delinquent 60 days after insurance payment, your account will be sent to our collection agency. You will be responsible for all collection fees incurred.
10. Please be prepared to show your insurance card **AT EVERY VISIT** for us to prepare for possible changes to your insurance coverage.
11. If you have questions about these policies please direct them to the office manager.
12. We will send all pathology samples to Miraca Life Sciences. If you prefer us to send the pathology to another lab please specify below: _____. If your insurance does not cover Miraca Life Sciences and you did not specify a different lab above, you will be responsible for any charges incurred.

_____

Patient or Guardian Signature

- 241 Monmouth Road, Suite 101, West Long Branch, NJ 07764
- 901 West Main Street, Suite 201, Freehold, NJ 07728

Phone: 732-222-2250, Fax: 888-218-8335