GARDEN CITY DERMATOLOGY, PC and THE GARDEN SPA-OFFICE POLICIES AND FINANCIAL AGREEMENT

Thanks you for choosing our practice. We are honored by your choice and are committed to providing you with the highest quality medical treatment and care.

We have outlined the information below to reduce any confusion and/or misunderstanding between our patients, the practice and your insurance carrier. We regard your complete understanding of our office policies and your financial responsibilities as an essential element of your care and treatment. If you have any questions about the policies, please discuss them with the office manager.

- Patients must complete all patient information forms prior to being seen by a provider. We will collect a photocopy of your insurance card for your file. Under the "RED FLAG IDENTITY RULE" we are legally required to collect a picture ID from all patients 18 years of age or over OR from the parent/legal guardian of all minor children/patients.
- We reserve the right to charge a $25 service fee for appointments cancelled with less than 24 hours notice, so please contact the office during office hours of 9 am – 5pm if you should need to cancel. We also reserve the right to charge a $25 service fee for any no show appointments-any deposit left on the account may be forfeited as well. If you late cancel or no show for more than two appointments, deposits to hold future appointments will be expected.
- Cosmetic procedures and appointments requiring an extended time slot require a minimum of $25 deposit at the time of booking your appointment. Certain cosmetic procedures will require a deposit of 50% at the time of booking your appointment. These deposits will be applied to any late cancel or no show fee if the appointment is not met by the patient. The balance of the payment on all cosmetic services is due prior to the service being performed.
- 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.
- Upon check in, we will collect any copayments, prior balances and payment for any uncovered services and/or your deductible, coinsurance portion as determined by your insurance carrier. Our practice is obligated by state and federal law to collect your insurance carrier's assigned copay, deductible and coinsurance. Each plan determines its own fees. It is your responsibility to provide our practice with your current insurance information along with your current demographic information.
- Self pay patients (those patients who elect to not carry health insurance) will be required to pay for services at the time of visit.
- A $20 billing fee will be added to any unpaid balances over 60 days. If an outside collection agency is required to collect the unpaid balance, you will be held responsible for your original balance, and all $20 billing fees and 1.5% monthly interest. This agency will report your failure to pay to the three national credit reporting agencies.
- The parent/legal guardian who consented to the treatment of a minor child is responsible for payment of any fees not paid by the child's insurance carrier and for any fees due at the time of visit. Garden City Dermatology will not be involved with separation or divorce disputes.
- Garden City Dermatology reserves the right to pursue legal action against anyone who posts false statements about the practice, its providers and/or its staff members on any internet site or social media platform.
- The patient agrees that any civil or medical malpractice claims or any claims will be settled by arbitration. Any demand for arbitration triggered by this Agreement must be made before the statute of limitations applicable to such a claim has run or will be considered void.
- We will submit claims to Medicare. You will be responsible for the deductible and the 20% coinsurance, which can be billed to a secondary carrier, 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 for evaluation and administering claims and benefits.

I understand that I am giving my consent to Garden City Dermatology to use and disclose my healthcare information to carry out treatment, payment activities and healthcare operations of this practice. I authorize the release of my medical information as necessary to process insurance claims. I herby authorize Garden City Dermatology to apply for benefits on my behalf for services rendered and that payment from my insurance carrier be made directly to Garden City Dermatology. I further understand that I am financially responsible for all services rendered for the following reasons: I do not have a proper referral, my referral is expired/invalid, I have given incorrect/invalid insurance information, expenses were not covered by my insurance carrier, I have not met my deductible, my insurance plan requires that I am seen by an in network provider and our providers are deemed as out of network and/or the services rendered are deemed medically unnecessary by my insurance carrier. I accept full responsibility for payment of my account. Your signature below signifies your understanding and willingness to comply with the polices of this office.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER CARDS (AND CARE CREDIT FOR SERVICES OVER $200)

Patients Name____ DOB: _______/_______/_______

Responsible party signature______________________________________ Date:_________________________

(If patient is under 18, Parent or Guardian must sign)

Print Name: ____ Relation ship:__________________