

**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, an administrative fee of \$10.00 may be added to your account.
- **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 and interest, late fees, as well as additional collection fees on amounts due so that Garden 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.

Patient’s Name: \_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If patient is under 18, Parent or Guardian must sign)

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_