CERTIFIED DERMATOLOGY

PATIENT RESPONSIBILITY REGARDING PAYMENTS

Your insurance coverage is a contract between **YOU AND YOUR INSURANCE COMPANY** (not this office). As such, you acknowledge and agree that:

- Payment of your deductible is your responsibility (even Medicare has a deductible).
- Co-payments are your responsibility and are due at the time of your visit.
- Co-insurance payments are your responsibility.
  Example: If your insurance company pays 80% of covered/discounted charges, you will be responsible for 20% of covered/discounted charges. The 20% is called the co-insurance.
- If you have secondary insurance, we will submit the 20% for reimbursement.
- Referrals, if required are the responsibility of the patient. **YOU WILL NOT BE SEEN OR YOU WILL BE RESPONSIBLE FOR THE BILL** if you do not have the proper referral
- **IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH CURRENT INSURANCE INFORMATION** as well as the subscriber information for your policy. If incorrect information or outdated information is given to us, you will be responsible for your bill. Filing insurance claims is a service provided by this office and in no way relieves you of the financial responsibility of paying your bill.
- IT is your responsibility to confirm that your insurance coverage is in effect at the time of your visit and to respond to your insurance company's request for any additional information needed from you to process the claim. **IF YOU ARE NOT COVERED AT THE TIME OF YOUR VISIT YOU WILL BE RESPONSIBLE FOR THE BILL.**
- We accept assignment with most insurance companies and Medicare. We DO NOT accept State Medicaid, however we do participate with most Medicaid HMO plans.
- **YOU ARE RESPONSIBLE FOR FORWARDING TO OUR OFFICE ANY PAYMENTS SENT DIRECTLY TO YOU BY YOUR INSURANCE COMPANY, ALONG WITH THE EOB (Explanation of Benefits).**
- It is your responsibility to advise this office which lab your insurance company is affiliated with.
- In cases of divorced or separated parents, our policy is that the parent accompanying the child to the office visit is responsible for full payment of all fees.

I am in agreement with the office policy and patient responsibility set forth above

Signature: _____ Date: _____

Credit Card Authorization:

By signing this form, I authorize Certified Dermatology of NJ to charge my credit card for any balance remaining after my insurance company has been billed. I understand that my health plan will be billed prior to charging my credit card and that my credit card will not be charged until my health insurance plan responds to the claim. I further understand that for any balance which exceeds $100.00 I will receive a phone call prior to charging my credit card. In the event that there are any problems with my credit card, I will be responsible for all monies associated with collecting this debt from me.

Signature: _____ Date: _____

Print Name: _____