FRYER DERMATOLOGY, PLLC
210-08 Northern Blvd, Suite 2
Bayside, NY 11361
718-224-8200/ fax 718-819-0244

FINANCIAL AGREEMENT

Fryer Dermatology, PLLC is committed to providing you with the best possible care. We are available at any time to discuss our professional fees. Your clear understanding of our Financial Policy is important to our professional relationship. If you have any questions regarding your financial responsibility or our financial policy, please feel free to ask.

ALL FORMS MUST BE COMPLETED PRIOR TO SEEING ONE OF OUR PROVIDERS. WE REQUIRE A PHOTOCOPY OF YOUR INSURANCE CARD AND THAT YOU PROVIDE YOUR INSURANCE CARD TO OUR STAFF UPON REQUEST. IT IS THE RESPONSIBILTY OF THE PATIENT TO PROVIDE OUR OFFICE WITH ACCURATE INSURANCE INFORMATION.

APPOINTMENTS: In the event that an appointment cannot be kept, our office requires 24 hours notice. In the event of excessive cancellations, or missed appointments, our office may require that a deposit of $25 be made prior to scheduling future appointments. This fee will be refunded or applied to your copayment as applicable. In the event that the appointment is not kept, the $25 fee will not be refunded.

REFERRALS: Referrals are the responsibility of the patient. If your plan requires a referral it is your responsibility to obtain one from your primary care provider. In the event that you do not have the necessary referral for your visit, you will be required to pay for the visit. If the appropriate referral is received after the visit you will receive a refund.

CO-PAYMENTS: Our office is required by law to collect your carrier designated co-payment. Co-payments are due at the time of your visit. Co-payments are due at every office visit *regardless of the reason for your visit.* In the event that you do not pay your co-payment at the time of your visit and we have to bill you, you will be charged an additional $10 fee.

DEDUCTIBLES AND CO-INSURANCE: Many insurance policies have deductibles and co-insurance requirements. These are fees that your insurance company designates as your responsibility to pay towards the cost of some procedures and even some office visits, even for providers in your network and even beyond your copayment. These fees will apply even to services that are "covered" by insurance. **Once again, this is determined by your insurance company, *not* by our office.** We are required by law and by our contractual agreements with your insurance company to collect these fees from you. You are responsible for payment of these fees. You are also responsible of knowing the details of your deductible and coinsurance obligations. If you have questions regarding these fees you must contact your insurance company as our office will not be able to advise you on the specifics of your individual policy.

PREVIOUS BALANCES: Previous balances are collected at the time of service. You may be asked to pay your balance prior to being seen by one of our providers. *Balances owed for deductibles and/or co-insurance from previous visits are due at the time of service.* You are responsible for responding promptly to requests from us or your insurance company to provide any additional information required from you. Any claims unpaid due to your failure to provide timely information will become due from you and payable in full.

DEPOSITS: All cosmetic procedures and/or procedures not covered by your insurance require a deposit of $200. If the fee for the procedure is less than $200, you will be required to provide a deposit of 50% of the fee for the procedure. Deposits are applied to the cost of the procedure. In the event that 24 hours notice is not given and/or the appointment is missed, you may lose your deposit.

SELF-PAY PATIENTS: Payment in full is due and payable at the time of service.

MEDICARE: We will submit claims to Medicare. You are responsible for your deductible and the remaining 20% that is not covered by Medicare. We will bill your secondary insurance if applicable.

Medicare lifetime signature on file: I request that payment of authorized Medicare benefits be made on my behalf to FRYER DERMATOLOGY, PLLC for any services furnished to me. I authorize any holder of medical information about me to release to FRYER DERMATOLOGY, PLLC (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. FRYER DERMATOLOGY, PLLC will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Should it become necessary for our office to use an outside agency to collect payment from 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 FRYER DERMATOLOGY, PLLC receives full reimbursement

of monies due. I understand that I am responsible for any and all services not covered by my insurance company. I accept responsibility for payment of my account. I have read the financial agreement and accept the terms of the agreement.

FRYER DERMATOLOGY, PLLC accepts cash, credit card (Visa, MasterCard, or Discover) and checks. We do not accept checks for cosmetic procedures.

Patient's name: _____ Date of Birth: _____

Responsible Party Signature: _____ Date: _____

Print name: _____ Relationship: _____