DERMATOLOGY ASSOCIATES OF CENTRAL NJ

3548 Route 9 South, 1st Floor, Suite 2 • Old Bridge, NJ 08857 • Tel.: (732) 679-6300 • Fax: (732) 679-9566
57 Schanck Road, Suite C-6 & C-7 • Freehold, NJ 07728 • Tel.: (732) 780-7870 • Fax: (732) 252-9703
440 Chestnut Street, 1st Floor, Suite 101 • Union, NJ 07083 • Tel.: (908) 623-3539 • Fax (908) 378-5702

To Our Patients:

OUR INTERNAL FINANCIAL POLICY AND WHAT ACCEPTING INSURANCE ASSIGNMENT MEANS:

You ***must*** present your current insurance card(s) and a **Government Issue photo ID** at the time of service. All co-pays and other balances are due prior to treatment. **Self-pay patients are required to make full payment up front at the time of your visit.** WE ACCEPT CASH, CHECK OR CREDIT CARDS (Visa, Amex, Discover or Mastercard). A $30 fee will be applied to any account with a returned check for insufficient funds.

No enrollment forms will be accepted if your benefits and eligibility cannot be verified on the day of your visit. If you do not have your insurance card and we cannot check your benefits and eligibility, you will have to reschedule. If you are a college student and you are under a parent's or guardian's insurance policy, please provide a copy of full time school schedule to your insurance company. (**Note:** Most insurance companies **will not process** any claim if they do not have a record of full time status from school).

You are responsible for knowing your insurance requirements including referrals, authorizations numbers and medical claim forms (if applicable). **YOU ARE RESPONSIBLE TO HAVE THIS ON HAND BEFORE YOU ARE SEEN BY THE DOCTOR.** If you are seen without a referral there will be an administrative fee of $200.00 applied to your account.

You are also liable for deductibles, co-payments and non-covered services for ***any*** type of consultation done by the doctor, as they are part of your contract between you and your insurance company. If your insurance company refuses to pay or ignores our claims, you will also be responsible for payment. If your insurance company goes bankrupt you are responsible for your balance.

For established patients: **any personal changes that occur; (i.e. name, address, insurance name, guarantor, phone number, etc) you must fill out new forms. You will also need to update your personal information on a yearly basis.** Any incorrect information may cause your insurance company to delay or decline payment.

Any requested documentation such as: disability papers, medical necessity letters, medical records, etc will be completed within 30 business days from the time we received them. YOU WILL HAVE TO PICK UP THIS DOCUMENTATION. WE ARE NOT RESPONSIBLE FOR MAILING OR SUBMITTING ANY DOCUMENTATION. In order to release any medical records and in accordance with HIPPA a valid record release form must be on file prior to initiation of this process. The release could be signed with your new physician or in our office with the information of the new physician.

Note: It is important that we know what laboratory your insurance will allow you to participate with. Failure to provide this information may result in fees being billed to you. Laboratory fees for analyzing biopsies, cultures, blood-work, and etc. will be billed to your insurance company by the performing laboratory. Our office Dermatology Associates has no authority over billing policies of these laboratories.

If you have any questions about your medical policy, please call your insurance company. They have final determination on everything. We only get quotes, not a guarantee of payment.

I _____ (print name) hereby understand the above premises and I am aware that I will be fully responsible for any non-payment from my insurance company and payment will be made in full within 30 days of billing statement. In the case that I cannot make full payment, I will let the office of *Santiago Centurion, M.D.* arrange a payment plan. I understand that I will be legally responsible for all collection costs, reasonable attorney fees, and all other expenses incurred with collection if I default on this agreement.

Thank you for understanding our Financial Policy.

Modified Sept 2010

Patients /Legal Guardian/ Guarantor **Signature** _____ **Date**_____

DERMATOLOGY ASSOCIATES OF CENTRAL NJ

3548 Route 9 South, 1st Floor, Suite 2 • Old Bridge, NJ 08857 • Tel.: (732) 679-6300 • Fax: (732) 679-9566
57 Schanck Road, Suite C-6 & C-7 • Freehold, NJ 07728 • Tel.: (732) 780-7870 • Fax: (732) 252-9703
440 Chestnut Street, 1st Floor, Suite 101 • Union, NJ 07083 • Tel.: (908) 623-3539 • Fax (908) 378-5702

www.dermatologyassociatesnj.com

To Our Patients:

In our efforts to go green and keep the cost of healthcare down we have implemented the following policy.

If we are providers for your insurance company, you will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of your financial responsibility. At that time, any remaining balance due to Dermatology Associates of Central NJ will be charged to your credit card. If we are NOT providers for your insurance plan, the office policy remains the same: you will pay in full at the time of your visit. **It is in your best interest to understand your insurance plan.**

This credit card policy will be an advantage to you as you will no longer have to prepare and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and post in the mail. This policy benefits everybody by keeping the cost of healthcare down, and by allowing us to concentrate first and foremost on your medical needs.

Our credit card on account policy in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays, Co-insurances, and deductible amounts will, of course, still be due at the time of your visit.

Please note, any charges over $150 will receive a courtesy call to advise that we will be charging this to your credit card on file.

If you have any questions, please do not hesitate to ask.

****

I authorize Dermatology Associates of Central New Jersey to charge outstanding balances on my account to the following credit card. If the billing address for this credit card differs from your home address, please advise us of the billing address. Thank you.

Visa ___ MC ___ AmEx ___ Discover ___

CC Number Last 4 digits only _____ Exp Date ____/____ Security Code _____

Name on Card (Print) _____ Primary Phone # _____

Patient Name _____ Patient DOB _____

Signature _____ Date _____