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
780 Route 37W, Ste 100 • Toms River, NJ 08755 • Tel.: (732) 679-6300 • Fax: (732) 679-9566

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**_____