Office Policy on Insurances and Payments

As a courtesy service to you, our office employs a billing service and participates with several insurance carriers. Please familiarize yourself with your insurance practices and policies.

1. If your insurance carrier requires you to pay a portion of your healthcare visits (i.e. Co-payment, Deductible, Co-insurance), we are legally required to collect these and no exceptions will be made. You are required to pay your Co-payment at the time of your visit.

2. If your insurance carrier requires you to have a referral to be seen in our office, you must provide a referral or you will not be seen.

3. If your insurance requires you to meet an annual deductible before your healthcare is covered, you will be billed for the services rendered if you have not met your deductible.

4. You will be asked to leave a credit card number at the time of check-in. This will be held securely until your insurances have paid their portion and notified us of your share. At that time, any remaining balance owed by you will be charged to your credit card and a copy of the charge will be mailed to you.

Please note that this will not compromise your ability to dispute a charge or your insurance company's determination of payment. Unless otherwise specified, we will contact you via email regarding your balance.

Please check here ___ if you do not wish to be contacted via email and prefer correspondence via regular postal mail.

I _____(print name) authorize ***Tribeca Park Dermatology*** to charge outstanding balances to my credit card on file.

Card Type: VS___ MC___ AMX___ DSC___ Last 4 digits: ___-___-___-___ Exp Date: ___/___

IS THE CARD PROVIDED AN HRA OR FLEX SPENDING ACCOUNT? YES____NO____

Circle One Credit card billing address is the **same** / **different** from current address.

The correct address associated with the card provided is:

Street Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

I have read the above and acknowledge these terms. I hereby assume all responsibility for any outstanding balances and (if selected) understand that these charges will be applied to the credit card I have provided.

Sign_____ Date _____

(Please PRINT carefully)
NAME:_____

Card Type	Account Number	Expiration Date	Security Code
Visa			
Discover			
Master Card			
American Express			

(PLEASE INDICATE IF THE CARD PROVIDED IS AN HRA OR FLEX-SPENDING ACCOUNT)