**LASER & SKIN SURGERY CENTER OF NEW YORK PHYSICIANS FINANCIAL POLICY**
**PHARMACY INFORMATION AND HIPAA PRIVACY & NOTIFICATION**

Thank you for choosing the physicians at the Laser & Skin Surgery Center of New York for your health-care needs.

**The following is our payment policy which we require you to read and sign prior to your visit (s).**

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. To ensure that we have accurate information to process your claim, we will make a copy of your medical insurance and/or Medicare card at the time of your appointment.

You are required to inform us immediately of any changes in demographic information or medical insurance information. Patients without medical insurance are required to pay in full at the time of service.

**PARTICIPATING PLANS**
You must present your insurance card, and if applicable, your insurance referral form, at every visit. We will submit bills directly to your insurance company for payment on your behalf. Patients without insurance cards or proper referrals will be asked for full payment at the time of service. All co-pays, deductibles and non-covered services will be collected at the time of service. Some insurance plans may send payments directly to you. If you receive payments for the services received, you are responsible for forwarding the check to The Laser & Skin Surgery Center of New York.

**NON-PARTICIPATING PLANS**
If your provider does not participate in your insurance plan, you are responsible for payment of all charges at the time of service. We will provide you with a receipt that you can submit directly to your insurance carrier.

**COSMETIC SERVICES / NON-MEDICALLY NECESSARY SERVICES**
Payment in full is due at the time of service for the consultation and all non-medically necessary services and/or cosmetic services. The consultation fee is $400/$450 in addition to all bills for services rendered.

**USUAL AND CUSTOMARY RATES**
Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**MINOR PATIENTS**
For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

**COLLECTION ACCOUNTS**
For all accounts with balances that are submitted to our collection agency for collection, you will be responsible for all legal and court fees as well as an additional fee of $25.00 for submission to our collection agency.

**PAYMENT**
For your convenience, the following payment methods are accepted: CASH, PERSONAL CHECK (for established patients only), VISA, MASTERCARD, AMERICAN EXPRESS, and DISCOVER. There is also financing available with CareCredit and Parasail.

I have read the policy, I understand and agree to it.

_____ _____

*(Signature of the Patient or Responsible Party)* *(Date)*

_____

*(Please Print the Name of the Patient)*

## PHARMACY INFORMATION

**NAME OF PHARMACY:** _____

**ADDRESS:** _____

_____

**TELEPHONE NUMBER:** _____

My signature below acknowledges that I understand that all prescriptions are e-prescribed.

## HIPAA PRIVACY NOTICE

My signature below signifies that I have read, reviewed and have been offered a copy of the HIPAA privacy notice.

## NOTIFICATION

My signature below acknowledges that it is the office policy not to testify in court, depositions, arbitrations, etc. relating to Worker's Compensation and other personal injury action.

## ANSWERING MACHINE NOTIFICATION

I give permission for a message to be left on my answering machine at home and/or on my cell phone.

Please circle: YES OR NO

_____ _____

Patient Signature Today's Date