Weill Cornell Medicine
Dermatology

Patient Name: _____

MRN#: _____

The following is our Financial Policy which we require you to read and sign prior to your visit(s).

Thank you for choosing WCM- Dermatology to provide your health care. We are committed to your successful treatment.

You are required to inform us immediately of any changes in demographic (home address, telephone numbers) Or medical insurance information. You are expected to pay all previous outstanding balances prior to scheduling the next visit. If you have questions about billing, please ask to speak with one of our Billing Representatives or call 646-962-4521.

If we are participating providers: You must present your Insurance Card, and, if applicable, Insurance Referral Forms at every visit. We will submit bills directly to your insurance company for payment on your behalf. Patients without insurance card(s) and/or a proper referral will be asked for payment in full at time of service or to reschedule the visit. **It is the patient's responsibility to obtain new and up to date Insurance Referrals, if applicable.** All co-payments and cosmetic charges will be collected at time of service. In the event that your insurance coverage changes to a plan where we are not participating providers, please refer to the below section.

_____*Initial*

We are legally required to collect your copayments, coinsurance and or deductibles: The Health Care Financing Administration (otherwise known as HCFA) is the federal government agency responsible for setting policy and overseeing the Medicare and Medicaid programs. HCFA has mandated that physicians and other providers of health care must collect co-pays, deductibles and co-insurances. This is enforced by the Office of the Inspector General (OIG). Copays, coinsurance, and deductibles are all part of Insurance cost-sharing, or your out-of-pocket costs agreement. This agreement is between you and your insurance company. You are responsible for Out of pocket costs applied by your insurance company.

_____*Initial*

If we are Out of Network with your insurance plan Or You do not have medical insurance: Payment is due at time of service. It is the responsibility of the patients to submit an original claim and receipt directly to their insurance company along with any pertinent information/documents. _____*Initial*

Cosmetic Services

Payment in full is due at the time of service for all services that are considered not medically necessary or cosmetic. (E.G. Botox, Cosmetic fillers, Laser services, Cosmetic removal of lesions) Understand that medicine is not an exact science and the possibility that the treatment may not have the benefits or results intended exists. There are no refunds after procedure is complete.

_____*Initial*

24 Hour Cancellation & "No Show' Fee Policy. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, we reserve the right to charge a fee for all missed appointments ("no shows") and appointments which, absent of a compelling reason, are not cancelled with a 24-hour business day advance notice. The fee for a missed office visit is $75.00 or $150.00 for a missed procedure visit. This charge is not reimbursable by your insurance company. You will be billed directly for it.

_____*Initial*

Laboratory and Pathology Fees: Many times it is necessary to obtain tissue or perform lab tests to confirm a diagnosis or to determine a course of treatment. If any tissue is removed for a pathology examination or if a laboratory test (blood work, culture, etc.) is done in our office, the actual test is performed by that department. This means you may receive a separate bill from the Weill Cornell Medicine - Dermatopathology Department and/or the New York Presbyterian Laboratory for the processing of these tests. You are responsible for payment to those departments. If you receive a bill from the lab, please contact that lab directly to resolve any billing concerns. _____*Initial*

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 for our patients 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.*

We appreciate your faith and trust in us and thank you for the opportunity to serve your healthcare needs.

I authorize payments to be made directly to the Weill Cornell Medicine- Department of Dermatology and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my medical insurance claims. Refusal to Initial and/or Sign this document does not remove your financial responsibility and/or obligations to its contents.

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

_____	_____	_____
Print Name of Patient or Responsible Party	*Signature of Patient or Responsible Party*	*Today's Date*