THE ROCKOFF DERMATOLOGY CENTER

PATIENT FINANCIAL AGREEMENT

Thank you for allowing us to serve you. As an accommodation to our patients, we have adopted the following payment policy, which will let us continue to provide the best care in the most efficient way. Should you have any questions or concerns regarding this matter, our Office Manager will be happy to speak with you personally.

Patient Responsibilities

- You are responsible to provide us with accurate billing information for you and each family member at the time of the visit.
- If your insurance requires you to have a referral from your Primary Care Provider (PCP). It is your responsibility prior to your visit to ensure that you have a referral or an authorization for your visit at the Rockoff Center.
- Our billing coordinators are available to provide assistance with explanation of benefits and deductibles details , but cannot resolve ant dispute between you and your insurance company
- Payment for non-covered services are due on the day of service

Deductibles

- It is the patient's responsibility to understand any deductibles that may apply under their Insurance policy.
- All insurance deductibles are the patient responsibility and due for payment
- Our billing department will send you a statement of the amount your insurance company has applied to your deductible

Copayments

- You insurance company requires you to pay your copay at the time of each visit. Copayment are due on day of service
- The Rockoff Center accepts all forms of payments (cash, checks and all major credit cards)
- There is a $25 assessed fee for any returned check.
- If you do not have insurance coverage and you are self pay , payment is due at the time of your visit

Insurance information

- The Rockoff Dermatology Center is contracted with most major insurance plans. It is the patient's responsibility to call the number listed on the insurance card and verify coverage, deductible and copayments
- It is the patient's responsibility to ensure that accurate insurance information are presented at the time of the visit. We ask that patients present their insurance card and photo identification at the time of their visit.
- If insurance is inactive or invalid , the patient will be responsible for full payment at the time of service

Missed appointments

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A 24 hour notice is required for canceling or rescheduling any office appointments at the Rockoff Dermatology Center. A $50 no show fee will be assessed if our office is not notified within 24 hour of the scheduled visit.

Assignment of Benefits

I hereby request that insurance payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Alan Rockoff, MD LLC for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity (your insurance) to determine these benefits payable for related services.

Guarantee of Payment

I understand that I am financially responsible for all charges whether or not paid by my insurance. I agree to pay all applicable copayments, coinsurance, deductibles and out of pocket expenses to Alan Rockoff MD LLC no later than then 60 days from today's date.

If you have any questions about: our financial policies or any uncertainty regarding insurance coverage. Please do not hesitate to ask us. We are here to help you.

I have read, understand, and agree with the above Financial Policy.

Patient Name:_____

Signature (Patient or Parent of Minor):_____Date_____