



DANIEL SIEGEL, MD ANTHONY WONG, MD DARREN MOLLICK, MD

MOHS MICROGRAPHIC SURGERY ■ DERMATOLOGIC SURGERY

PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our practice manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Your insurance policy is a contract between you and your insurance company only. If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.
- If you have insurance coverage with a plan that we do not have a prior agreement with, we will prepare and send the claim for you. Therefore, our charges for your care and treatment are due at the time of service.
- Unless either you or your health coverage carrier have made other arrangements in advance, payment is due at the time of service. For your convenience we will accept VISA, MasterCard and American Express. If you have a financial hardship, arrangements for a financial plan can be made.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered”, you will be responsible for the complete charge.
- For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred.
- In order to provide the best possible service and availability to all of our patients, please call us as early as possible if you know you need to reschedule your appointment.

GUARANTEE OF PAYMENT FORM

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, co-payments, any service that is not covered by your insurance plan and any service that your insurance company has determined not to be “medically necessary”.

Provider Name: Long Island Skin Cancer and Dermatologic Surgery, PC

I have read and understand the information above. I understand that my insurance company may deny coverage and request that Long Island Skin Cancer and Dermatologic Surgery, P.C. perform this medical service anyway. I agree to be personally and fully responsible for all charges. I understand that the provider named above is relying on this promise and is rendering services without requiring payment at the time of service based on such reliance.

X		
Patient or Guarantor	Print Name	Date
Witness	Print Name	Date

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