Jeri K. Mendelson, MD, FAAD

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FINANCIAL POLICY:

Thank you for choosing our office for your Dermatology needs. We are committed to your successful treatment.

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which you are required to read and sign prior to your treatment.

- **ALL PATIENTS MUST COMPLETE OUR INFORMATION AND PROVIDE CURRENT INSURANCE ID CARD(S).**
- **FULL PAYMENT IS DUE AT THE TIME OF SERVICE FOR CASH PATIENTS, UNLESS PRIOR ARRANGEMENTS ARE MADE. COPAYS, DEDUCTIBLES AND COINSURANCE ARE DUE AT THE TIME OF SERVICE FOR ALL OTHER INSURED PATIENTS.**
- **WE ACCEPT CASH, CHECK, CREDIT AND DEBIT CARDS. THERE IS A $35 FEE FOR RETURNED CHECKS.**
- **ANY PATIENT BALANCE OLDER THAN 90 DAYS (AFTER INSURANCE HAS PAID) MUST BE PAID BEFORE WE WILL MAKE YOUR NEXT APPOINTMENT, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH OUR BILLING DEPARTMENT.**

INSURANCE COVERAGE:

If your insurance company requires a referral/authorization from your primary care provider, **it is your responsibility to obtain it from your primary care provider prior to your visit.** If you do not have a referral/authorization in place and your insurance company requires it, we may need to reschedule your appointment.

I hereby assign to RoxyAnn Dermatology, LLC all payments due by my insurance company for services rendered.

Thank you for understanding and cooperation with this policy. Please let us know if you have any questions or concerns.

I have read the financial policy described above. I understand and agree to all provisions of the financial policy.

Signature of Patient/Responsible Party:_____

Print Name: _____ Date: _____