DR. LYUBOV AVSHALUMOVA
80 BEEKMAN ST NEW YORK, NY 10038
P: 212-674-7777 F: 212-729-9395

AL DERMATOLOGY
PROFESSIONAL DERMATOLOGY SERVICES

212 729 SKIN

PATIENT NAME _____ **PATIENT DOB:** _____

Welcome to AL Dermatology PC. We are dedicated to providing you with the highest level of medical care in a compassionate and proficient manner. All patients are expected to complete a patient financial responsibility form annually. You will need to read carefully the Financial Policies as described below.

Your co-payment will be collected on the date of service. Any deductible, co-insurance, or full payment is due at the time services are rendered. We cannot waive co-payments, deductibles, co-insurance or non-covered service amounts defined as patient responsibility under the terms of our contract with various health plans.

For your convenience we accept cash, money orders, most major credit cards, personal checks and PayPal as an extended payment option. If you cannot provide a current medical insurance card, full payment must be made at the time services are rendered. It is your obligation to make certain that this office is a participating provider of your policy and that referral information and authorization has been obtained in advance of your appointment. We will file your insurance claims for you if all necessary information is received at the time of your visit. It is also your responsibility to inform our office of changes in insurance coverage and/or personal contact information.

If payment is not received from your insurance company within 45 days, you will be billed for the services rendered. You will also be billed for any services not covered by your insurance
company. An account for which no payment is received within 60 days and for which no payment arrangements are made may be sent to a collection agency. The balance will accrue a monthly interest fee and an additional fee for the expenses related to collections. Checks returned to our office for non-sufficient funds (NSF) will incur a $30 service charge.

Patients are seen by appointment. If you cannot keep your appointment it is your responsibility to call at least 24 hours in advance. We do understand that occasionally it will be necessary to change or cancel an appointment in less than 24 hours; however, if an appointment is missed without the required notice there will be a $50 charge for medical services and a $150 fee charge for cosmetic services.

We try to utilize contracted laboratories for biopsies. When skin growths are biopsied or removed, there are two separate charges. Charge for the actual biopsy/removal performed and lab charge for preparing and examining specimen slides under a microscope. Lab charges occur on a different date. If the specimen slides require a second opinion or special stain, an independent lab (not owned by our practice) will bill your insurance carrier for additional fees. If you have questions about these additional lab fees, please contact the lab directly as these fees are not charged by our office.

Unaccompanied minors must have a consent signed by a parent or guardian. Non-emergency treatment will be denied unless non-covered charges and co-pays have been paid and insurance billing is approved under the insured's policy. Co-pays and other charges can be paid via telephone by credit card.
Should you request copies of your medical records, there is a fee charged as allowed by current NYS statutes. There is also a cost associated with your request for physician "narrative reports" and/or letters not related to our insurance claims. These fees would be based on the complexity and amount of time involved.

I have read and understand the terms of this Financial Policy. I understand and agree that such terms may be amended from time to time by the practice. I agree to assign insurance benefits to AL Dermatology PC. I authorize the release of medical information to my primary care or referring physician, and/or consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

By signing this form I authorize 212SKIN AL Dermatology PC to assess applicable fees according to the above outlined policies to the credit card listed on my file.

Signature: _____ **Date:** _____

Printed Patient Name: _____

May we leave a message regarding your health or an upcoming appointment on your answering machine? YES __ NO ___