PORT JEFFERSON DERMATOLOGY
Dermatology - Adults and Children
Dermatologic Surgery and Mohs Surgery

www.portjeffdermatology.com

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FINANCIAL POLICIES

Personal Checks

The Practice accepts personal checks for co-payments and deductibles. In the event that a check 'bounces' (i.e., insufficient funds exist to cover the check), the Practice will apply a fee of $25. By signing below, I acknowledge and agree to abide by this policy.

Patients are responsible for balances not covered by their insurance policy (e.g., co-payments and deductibles). The Practice will mail invoices for all balances due and prompt payment is requested. Failure to settle balances in a timely manner may result in retention of a collection agency. Failure to settle balances may also result in a report to credit bureaus (e.g., Equifax) and may affect your ability to obtain credit in the future. By signing below, I acknowledge and agree to abide by this policy.

Failure to Appear for an Appointment

All patients receive a courtesy reminder call for upcoming appointments. Failure to call to cancel an appointment beforehand or failure to appear for an appointment (no show) will result in a fee of $35. A fee will not be levied as long as an appointment is canceled beforehand. By signing below, I acknowledge and agree to abide by this policy.

Failure to Appear for a Surgical Appointment

All patients are advised when booking surgical procedures that one week's notice is required to cancel without penalty. Failure to call or appear will result in a fee of $150. By signing below, I acknowledge and agree to abide by this policy.

Laboratory Charges and Deductibles

During your visit, skin biopsies or cultures may be obtained and sent to an outside laboratory. The Practice is in no way responsible for co-payments or deductibles levied by outside laboratories. By signing below, I acknowledge that the Practice cannot be held liable for these charges.

Payments to our office must be made in the form of Visa, MasterCard, Discover, check or money order.

This office does not accept cash or AMEX. We apologize for any inconvenience.

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Last name, First name

______________________________________   ______________________
Patient Signature   Date