

PORT JEFFERSON DERMATOLOGY  
DERMATOLOGY - ADULTS AND CHILDREN  
DERMATOLOGIC SURGERY AND MOHS SURGERY

WWW.PORTJEFFDERMATOLOGY.COM

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6 MEDICAL DRIVE, SUITE D  
PORT JEFFERSON STATION, N.Y. 11776  
P: 631-928-7922 | F: 631-928-9246

100 HOSPITAL ROAD, SUITE 116  
PATCHOGUE, N.Y. 11772  
P: 631-475-8249 | F: 631-475-8645

## **FINANCIAL POLICIES**

### **Personal Checks**

The Practice accepts personal checks for copayments 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., copayments 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 copayments 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, AMEX, check or money order.**

**As of July 1, 2022, due to dramatically increased costs, Port Jefferson Dermatology will be applying a 3.5% transaction fee for all debit and credit card transactions.**

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

\_\_\_\_\_  
Last name, First name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date