

PORT JEFFERSON DERMATOLOGY
DERMATOLOGY - ADULTS AND CHILDREN
DERMATOLOGIC SURGERY AND MOHS SURGERY
WWW.PORTJEFFDERMATOLOGY.COM

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6 MEDICAL DRIVE, SUITE D
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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. 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.

Failure to Appear for a Cosmetic Appointment

All patients are advised when booking cosmetic procedures that there is \$250 non-refundable deposit, if the appointment is canceled or missed.

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, money order or Healow Pay.

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

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

Last name, First name

Patient Signature

Date