Office Policy on Insurances and Payments

As a courtesy service to you, our office employs a billing service and participates with several insurance carriers. Please familiarize yourself with your insurance's practices and policies.

1. If your insurance carrier requires you to pay a portion of your healthcare visits (i.e. co-payment, deductible, co-insurance), we are legally required to collect these and no exceptions will be made. You are required to pay your co-payment at the time of visit and deductibles and co-insurances will be billed to you at a future date.

2. If your insurance carrier requires you to have a referral to be seen in our office, you must provide a referral or you will not be seen.

3. If a referral is required and if, for any reason, you have not provided a valid/un-expired referral at the time of your visit, you will pay for services rendered in full, as ensuring that a valid referral is in place is your responsibility and you agree that all charges resulting from a missing or invalid referral are your responsibility.

4. If your insurance requires you to meet an annual deductible before your healthcare is covered, you will be billed for the services rendered if you have not met your deductible.

5. I authorize the practice and its billing agent to apply for insurance benefits on my behalf. I authorize all insurance payments to be made directly to this practice. I authorize this practice to release to my referring physician and my insurance plan(s) all necessary information and/or medical information regarding all services rendered on me. The authorization to release medical information may be revoked in writing by me at any time.

Name: _____ Signature: _____ Date: _____

Credit Card Authorization

We ask you to leave a credit card number at the time of check in. This information will be held securely until your insurances have paid their portion and notified us of your share. Please be advised you will not receive a statement in the mail for your balance. Once your payment has been processed, you will receive a receipt for your payment via mail.

Please note that this will not compromise your ability to dispute a charge or your insurance company's determination of payment.

I _____ (print name) authorize Tribeca Park Dermatology to charge outstanding balances to the following credit card:

Card Type	Account number	Exp. Date	CVN
American Express			
Discover			
MasterCard			
Visa			
Flex-Spending / HRA			

Name on Card _____
Billing address _____
(if different from mailing) _____