Nigro Dermatology Group, P.A.
Adult & Pediatric Dermatology
Dermatologic Surgery & Cosmetic Dermatology

WELCOME

We are committed to providing you with quality medical care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

To assist us in establishing your account please (1) provide current insurance information on our new patient registration form and (2) authorize release of information necessary for insurance filing and pre-certification (sign on the sheet below). Failure to do so will affect your financial responsibility for charges incurred. Your payment can be in the form of cash, check or Visa/MasterCard.

REGARDING INSURANCE

Contracted managed Healthcare Plans (HMO, PPO, POS, EPO, and MC): Each time you make an appointment it is your responsibility to make sure this office is currently under contract with your plan and you have obtained the necessary referrals. Verification of your plan is required. Often this verification requires us to share the reasons for your visit with your managed care plan. Please plan to show your current card to our staff upon request. **Co-payment, co-insurance, deductible and/or fees for non-covered services are required at time of service.**

Insurance is a contract between you and your insurance company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered/covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply factual information as necessary. You are responsible for the timely payment of your account.

Many services performed in our office are considered surgical procedures by your insurance company. These services may be covered by your insurance company, but may be subject to a deductible or co-insurance. Any deductible, co-insurance, or non-covered service is your responsibility to pay and we may ask for payment at time of service. Surgical procedures may include, but are not limited to: treatment of warts and moll scum; removal of moles, skin cancers, benign growths, cysts; treatment of keratoses (pre-skin cancers); acne surgery; keloid treatments; nail surgery; drainage of abscesses.

After 60 days, it is the patient's responsibility to pay the balance of the account even if there is an insurance claim pending. We will no longer be responsible for collecting your insurance claim or for negotiating a settlement of a disputed claim.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge a fee for missed appointments. Please help us serve you better by keeping scheduled appointments.

I have read and understand the above terms and conditions and will verity so by giving my signature.

Patient/Responsible Party: _____ Date: _____/_____/_____

ASSIGNMENT: I hereby authorize payment directly to this office. Any changes to this authorization must be received in writing within 30 days of effective date.

Patient/Responsible Party: _____ Date: _____/_____/_____

I agree to the release of any and all medical information, including test results and financial information necessary to process this and any future claims to my insurer or payor of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within 30 days of effective date.

Patient/Responsible Party: _____ Date: _____/_____/_____