Dr Ken Landow Dermatology

Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and agree to prior to any treatment.

A Patient Information form along with this Financial Agreement must be completed before seeing the doctor.

Proof of payment/insurance card and photo id are required for <u>all</u> patients.

Fees/Co-pays are payable when service is rendered.

You are responsible for knowledge of your own insurance benefits (**Deductible, Co-Insurance, Co-Pay details and if the physician is listed as participating under your insurance plan).**

We follow insurance carriers guidelines for PPO/EPO insurance plans. It is your responsibility to provide copies of current and accurate insurance information, including any updates or changes in carriers or primary insured. **Should you fail to provide this information, you will be financially responsible for all charges incurred.**

Please be aware that in some cases it will be necessary to utilize an **<u>"Outside Laboratory"</u>** and you may receive a **<u>separate</u>** bill from them **<u>in addition</u>** to any bill you may receive from us for services rendered. Should you have question regarding "Outside Laboratory" bills you will need to call them directly at the phone number listed on the statement received from the laboratory.

The adult accompanying a minor and the parents/guardians are responsible for full payment.

My signature below attests that all of the information on this document and registration is true, accurate, correct and current as of today. Any health insurance card I present belongs to me and it attests that it represents current and valid health insurance to help pay my debt to the provider. Any false information subjects me to pay the medical debt in full and I may be subject to any State or Federal legal action for possible fraud charges. I understand the provider does not have to submit a claim for me when the provider is not contracted with my health insurance. I understand this is my contractual responsibility. I understand that having health insurance doesn't mean that my claim will be paid and that I am responsible for appealing any denials or payments. I understand that I am responsible for ensuring that my debt with the doctor is paid in full.

Signature_______________________________________ **Date**________________________

If minor, Responsible Party's Name____________________ Relation to Patient_________________

Birth Date _______________ Social Security Number_________________________