Weill Cornell Medical College

Department of Dermatology
1305 York Avenue. 9th Floor, New York, NY 10021
Phone: 646-962-3376 Fax: 646-962-0033

Patient Name_________________________________ **Medical Record number**________________

Thank you for choosing WCMC Department of Dermatology to provide your health care. We are committed to your successful treatment.

The following is our Payment Policy which we require you to read and sign prior to your visit(s).

Patients without medical insurance are required to pay in full at time of service.
You are expected to pay all previous outstanding balances prior to scheduling the next visit.

You are required to inform us immediately of any changes in demographic (home address, telephone numbers) or medical insurance information.

If you have a financial hardship, or have questions about billing, please discuss with our Billing Specialist or call 646-962-4521 prior to your visit.

If we are participating providers:

You must present your Insurance Card, and, if applicable, Insurance Referral Forms at every visit. We will submit bills directly to your insurance company for payment on your behalf. Patients without insurance card(s) and/or a proper referral will be asked for payment in full at time of service or to reschedule the visit.
It is the patient's responsibility to obtain new and up to date Insurance Referrals if applicable.
All co-pays, deductibles and non-covered services will be collected at time of service. In the event that your insurance coverage changes to a plan where we are not participating providers, please refer to the below section.

We are legally required to collect your copayments and or deductibles:

The Healthcare Financing Administration (otherwise known as HCFA) is the federal government agency responsible for setting policy and overseeing the Medicare/Medicaid programs. HCFA has mandated that physicians and other providers of care Must Collect Copayments and Deductibles. This is enforced by the Office of Inspector General (OIG). The reasoning behind this is that if your doctor waives your copayment or deductible he/she is in effect giving you a discount. Therefore if he/she is willing to provide this service to you at a discount, he should also give a discount to the Insurer. The second reason is that the insurers objective for requiring copayments and deductibles is to cause you (the insured), to have a shared cost of your healthcare, thereby reducing unnecessary consumption of covered services.

We understand that sometimes financial hardships may affect your ability to pay in full. We will always do everything we can to work with you. However we ask that you contact us as soon as possible to discuss an arrangement that is satisfactory for everyone.

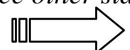
If we are non-participating providers:

If we are not participating providers, full payment is due at time of service. It is the responsibility of the patients to submit an original claim directly to their insurance company along with any pertinent information/documents.

Cosmetic /Non Medically Necessary Services

Payment in full is due at the time of service for all non-medically necessary and/or Cosmetic Services.
No Exceptions.

(see other side)



Usual and Customary Rates

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

For your convenience, the following payment methods are accepted:

- Cash
- Personal Checks
- Visa, MasterCard, American Express, Discover
- New patients are required to show ID (State or Government Identification)
- There will be a fee of $20.00 for returned checks.

We appreciate your faith and trust in us and thank you for the opportunity to serve your healthcare needs.

I authorize payments to be made directly to the Weill Cornell Medical College Department of Dermatology and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my medical insurance claims.

I have read the policy; I understand and agree to it.

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Print Name of Patient or Responsible Party

__________________________________ _____________________
Signature of Patient or Responsible Party Today's Date