GATEWAY DERMATOLOGY
1 SOUTH WESTERN AVE
GLENS FALLS, NY 12801-3304
Phone: (518)-745-5280
Fax:(518)-745-5284

Thank you for choosing GATEWAY DERMATOLOGY as your health care provider. Please review our Financial Policy.

- **PAYMENT IS DUE** AT TIME OF CONSULTATION OR OFFICE VISIT
- **WE ACCEPT Cash, Checks, Visa, Master Card, Discover OR Money Orders**
- AS OF APRIL 1, 2015 THERE WILL BE A $5 BILLING FEE PER STATEMENT ON BALANCES OVER 30 DAYS OLD. THIS EXCLUDES MEDICARE AND ACCOUNTS THAT HAVE MADE A PERSONAL PAYMENT WITHIN THE PAST 30 DAYS.
- FOR COSMETIC SERVICES, CONTACT THE OFFICE FOR OUR POLICIES.

Insurance Policies
Your insurance policy is a contract between you and your insurance company. Professional care is provided to you, our patient and not to an insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We will gladly process your claim, but we request your estimated portion be paid at the time of service. To do so, we require your complete insurance information. In the event we do accept assignment of benefits, please know that the balance of your bill is still your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 30 days, you will have 30 days to arrange payment of the balance due. Regarding insurance plans in which we are a participating provider, please understand that we do require payment of co-pays and deductibles prior to treatment.

Managed Care Insurance
Patients enrolled in a managed care health plan are expected to remit appropriate co-payment upon arrival at the office for the appointment. After the practice receives payment from the insurance company and discount adjustments have been posted, the patient is responsible for any balance due.

Insurance Authorization and Assignment
I request that payment of authorized insurance benefits be made on my behalf to GATEWAY DERMATOLOGY for any services furnished me. I hereby authorize GATEWAY DERMATOLOGY to release any medical information necessary to process my claim. I permit a copy of this authorization to be used in place of the original. The authorization may be revoked either by me or my insurance company at any time in writing.

Missed Appointment Agreement
We will attempt to remind patients of their appointment 2 days prior by our automation company . After doing so, should the patient **not show** for their scheduled appointment,a **No Show** letter will be sent with a **$40 charge to the patient, or guarantor.** The patient will be unable to schedule any appointments until this fee is paid. It is the patient's responsibility to notify the practice **24 hours** in advance if unable to keep their scheduled appointment. (**Cosmetic** appointments require **48 hours** notice.)

I have read the financial policy. I understand and agree to this Financial Policy.

December 15, 2015

Patient's Name Signature of Patient/Responsible Party

FOR MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me by the physician or provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

Fay Staff December 15, 2015 Patient's Name (Please Print) Patient's Signature

Name of Medicare Supplement (MEDIGAP) Insurer:

I request that payment of authorized Medigap benefits be made either to me or on my behalf to GATEWAY DERMATOLOGY for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release the above named Medigap insurer any information needed to determine these benefits payable for related services.

Signature of Patient