Financial Consent

Financial Responsibility

By accepting any medical services or treatment, including but not limited to consultations, examinations, and surgery, you, the patient/responsible party, agree to pay Sheftel & Associates Dermatology, LLP, dba HealthySkin Medical & Cosmetic Dermatology, all charges for such services.

Fees and interest charges may be added on to the account if payment for services is delinquent and an outside collections agency is required.

Insurance Authorization and Assignment

I am aware that as a courtesy my insurance will be billed. It is my responsibility to follow up on any delinquent claims.

I hereby authorize HealthySkin Medical & Cosmetic Dermatology to furnish information to insurance carriers concerning myself or my dependents' illness or treatments. I assign the insurance benefits to HealthySkin Medical & Cosmetic Dermatology and direct my insurance carrier to pay those benefits directly to Sheftel & Associates Dermatology, LLP. I authorize HealthySkin Medical & Cosmetic Dermatology, to release medical information to other physicians when deemed necessary for my medical treatment. I understand that if my medical insurance does not pay for any reason it will be my responsibility to pay the bill in full, unless prohibited by law.

I understand that all co-payments required by health insurance are the patient's responsibility. If it becomes necessary to take enforcement to collect any amount due, whether in a court proceeding or otherwise, I understand I shall be responsible for all attorney's fees, court costs, and collection fees, as well as the value of time lost by the provider or employees of the provider, in any efforts to collect such debt.

Lab Specimens

Lab specimens will be sent to a reputable pathology lab. Such lab will bill their services separately. I understand I am responsible for any costs not paid for by insurance. I understand it is my responsibility to verify insurance benefits, including deductible balances and limits, co-insurance, etc.

Procedures

I understand any procedures received will be charged in addition to an office visit, and such procedures may be applied to a deductible. I understand I may be asked to sign a waiver as some procedures may not be covered by my health insurance, and I will be held responsible for payment of the charges.

PROCEDURES INCLUDE, BUT ARE NOT LIMITED TO: BIOPSIES, ELECTRO-CAUTERY, INJECTIONS OR APPLICATION OF MEDICINE, SKIN TAG REMOVALS, CRYOSURGERY (liquid nitrogen).

Finance Charges

Importantly, finance charges will be assessed on any outstanding patient balances at a rate of 1.5% per month.

Additionally, I understand that if I fail to cancel my appointment at least 24 hours in advance and/or no-show to my appointment, I may be charged a fee of $25.

By acknowledgement of this consent, I hereby authorize direct payment of surgical/medical benefits to HealthySkin Medical & Cosmetic Dermatology for services rendered by a provider of such group.

The Financial Consent will be signed electronically by you in the exam room. If you have any concerns regarding this consent, please address them with our front desk staff or our Practice Administrator prior to your appointment.

We accept the following payment types:	
▪ Cash	▪ Check
▪ Mastercard	▪ VISA
▪ American Express	▪ CareCredit
▪ PayPal	▪ Discover