SYLVIE D. KHORENIAN, M.D., P.C.
Cosmetic and Medical Dermatology
630 East Palisade Avenue
Englewood Cliffs, NJ 07632
Tel: (201) 503-0302
Fax: (201) 503-0309
E-Mail: Derma630@aol.com

FINANCIAL POLICY

We are committed to providing you with the best possible care and 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. Pease ask if you have any questions regarding our fees and policies.

There is no way we can possibly know, or keep up to date with each program's provisions. It is your responsibility to know and advise us of your plan's requirements in advance, each and every time we provide service. Please be advised that if we have not been informed of your program's requirements and if we provide a physician or laboratory service, you will be responsible for the fees.

We will do our best to comply with your company's requirements. **Patients must inform us of changes in information or insurance plans prior to seeing the physician.**

Participating Plans: By law we must collect your carrier designated co-pay at the time of your visit. We will submit claims. You are responsible for your annual deductible and the co-insurance.

Non-Participating or Out of Network Services: Payment in full is expected at the time of service unless arrangements have been made in advance with the office manager. You are responsible for your annual deductible and the co-insurance.

Medicare: We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Dr. Khorenian for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

Laboratory Services: Patients must inform the nurse prior to a diagnostic procedure, which laboratory is participating with your insurance.
Divorced/Separated parents of minor patients: The parent who consents to the treatment of a minor child is responsible for payment of service.

Payment is expected at the time of the visit and may be in cash, check, or credit card. We accept **Visa, MasterCard**, **and American Express**.

By signing below you agree to be financially responsible for medical services provided.

If you have Health Insurance, provide us with a current insurance card. You are responsible for payment of any copay, deductible, co-insurance amount or non-covered services. We also require credit card information and authorization. Charges or refunds to your credit card will ONLY be made once you insurer has provided us with you EOB (explanation of benefits). Failure to provide current insurance or credit card information will result in service charges to your account.

Patient Name: _____
Name on Credit Card: _____
Type of Credit Card: Amex _____ MC _____ Visa _____
Credit Card Number: _____
Expiration Date:_____ Security Code: _____

I authorize payment of any amount due after due after insurance adjudication. (co-payment changes, co-insurance, co-insurance amount, deductible).

Patient/Cardholder Signature: _____
Date: _____
E-mail address: _____

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient Signature _____ Date _____