SSMD

Sharon Scherl, M.D.
Sanjosh Singh, D.O.

FINANCIAL POLICY STATEMENT

Thank you for choosing our office for your dermatological care. In order to minimize confusion and misunderstanding between our patients and the practice, we have adapted the following financial policies. If you have any questions about our policies, please feel free to discuss them with one of our staff members. We are dedicated to providing you with the best possible care and services and we regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

GENERAL

Your insurance policy is a contract between you and your insurance company only. If you fail to notify our practice of any insurance change(s), you are fully responsible for any amount not paid by your insurance company. Each health plan varies in regards to deductibles, co-payments, and co-insurance. Terms are contracted between the insurance company and the patient at the time you accepted the insurance. It is your responsibility to be aware of your deductibles, co-payments, and co-insurances and any changes that are made to your health plan for it will be your obligation to remit all appropriate payments as outlined in your insurance policy. These policy requirements do not allow our practice to absorb any co-payments, co-insurance, or deductibles.

HMO/PPO/OTHER INSURANCE COVERAGE

We will require a copy of your insurance card and a valid/current driver's license or personal identification card upon check in. All co-payments are due prior to seeing the physician on the day of the visit. If your insurance carrier requires a referral from your primary care physician, this is your responsibility and must be present at the time of service. Failure to provide all necessary information may require you to pay the visit in full or to reschedule the appointment. It is your responsibility to keep track of your referral expiration dates and the number of visits given to you by your primary care physician. You will be responsible for all deductibles, co-insurance, co-payments, and any services denied by your insurance carrier as not medically necessary and/or not covered.

MEDICARE

Dr. Scherl/Dr. Singh is a participating Medicare provider and accepts Medicare assignment which is the ALLOWABLE charge approved by Medicare. Medicare will pay 50% of the allowable charges after you pay your annual deductible. You are responsible for any amounts applied to your deductible and the 20% coinsurance. If you have a secondary insurance, as a courtesy, we will submit any remaining balance to that particular carrier. You will be responsible for all deductibles, co-insurances, co-payments and/or and services denied by your insurance carrier as not medically necessary and/or not covered.

SELF PAY PATIENTS

For patients with no insurance, the guarantor is responsible for the bill at the time of service.

COSMETIC PATIENTS

Cosmetic procedures will not be submitted to your insurance company. Payment is due at the time of service.

MINOR PATIENTS

For all services rendered to minors, we will hold the parent or guardian accompanying the minor responsible for expenses incurred during the visit.

PAYMENTS

Payments can be made by cash, credit, or check. Patient balances are due immediately upon receipt of statement.

NO SHOW RESCHEDULING FEE

A charge of $25 will be applied for any appointment that is not cancelled or rescheduled within 24 hours of the appointment time.

COLLECTIONS

In the event that any action is brought to collection, I agree to pay any reasonable collections costs and/or attorney fees. My signature below indicates my understanding and full responsibility for the balance on my account for any professional services rendered at Dr. Scherl/Dr. Singh's office.

I have read and fully understand all of the information above.

Printed Name (Last, First): _____Signature: _____ Date _____/_____/_____

BENEFIT ASSIGNMENT

I hereby authorize the assignment of benefits (payments) directly to Dr. Scherl/Dr. Singh for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance company. I understand that copayments, deductibles and non-covered services are due in full at the time of service.

Signature of Responsible Party: _____ Date: _____/_____/_____

RECORDS RELEASE

I authorize the release of any medical information necessary for the purposes of processing claims with my insurance company.

Signature of Responsible Party: _____ Date: _____/_____/_____

45 Central Avenue, Tenafly, NJ 07670
office@scherlmd.com
P: 201-568-8400
F: 201-568-8554