

DOUGLASTON DERMATOLOGY

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TO ALL OUR INSURANCE PATIENTS

In an effort to keep your personal expenses down we are accepting assignment. **However this means:**

1. You must be eligible for the benefit.
2. Co-payment must be made by the patient at the time of visit.
3. If required, a referral or authorization of consent from your primary care physician (GP, Internist, Etc.) must be on file before you are examined or treated.
4. You, the patient, are responsible to obtain your referrals. If a referral is not obtained, you the patient will be responsible for payment in full.
5. You are responsible for payment of all deductibles as well as, any co-insurance payments due
6. If you have a high deductible plan, you are responsible for all charges incurred prior to meeting your deductible and any co-payments and co-insurances thereafter. These are the conditions of your policy that are chosen by you and your employer.
7. As a patient I agree that I will pay my deductible to the office and that if co-payment or co-insurance comes directly to me I will send this balance to the office.
8. I further agree that if the insurance company refuses to pay, that I am responsible and will pay the fees for services rendered in this office.

I hereby agree to all the terms and conditions set forth above.

Patient/Legal Guardian Name (Print)

Signature

Date