WARREN R. HEYMANN, M.D. (A, B, C)
STEVEN M. MANDERS, M.D. (A, B)
JUSTIN J. GREEN, M.D. (A)

ANALISA V. HALPERN, M.D. (A)
LACY L. SOMMER, M.D. (A)

HEYMANN, MANDERS & GREEN, LLC

Patient Name: _____ MR#: _____

BILLING POLICY

We welcome you to our dermatology practice. We will do our utmost to provide you with the finest care possible, and are grateful for your decision to choose our practice. Please feel free to ask us any questions pertaining to your medical condition or about our billing procedures.

Payment for services rendered is expected on the day of your visit if you do not have insurance. You may pay by cash, check, Visa, MasterCard, Discover, or American Express. If you have a private insurance plan, our billing service will submit your claim for payment as a courtesy. ***If we do not participate with your insurance, you will be expected to pay for the visit and/or procedure before you leave the office.***

It is required that you bring in your insurance card and proof of identification (e.g. driver's license or governmental issued identification card) at the time of your visit and at every visit thereafter. Our billing service cannot bill without proof of your identity and coverage. **YOU ARE RESPONSIBLE FOR UNDERSTANDING WHAT YOUR PLAN PROVIDES (INCLUDING KNOWLEDGE OF YOUR DEDUCTIBLE AND/OR COINSURANCE).**

We participate with the Medicare program. To those patients who are new to Medicare, please realize that you are responsible for paying the deductible and 20% of the accepted fee that Medicare allows.

We also participate with several HMOs and managed health care plans. ***Copayments are expected to be paid the day services are rendered***. If you are "out of network" you are responsible for payment at the time of service. We will provide you with an itemized receipt that you may use to submit to your insurer if you are entitled to get reimbursed for these services.

*****If a referral form is required, it is expected that you will bring it with you the day of your visit. If you have forgotten your form, we will kindly ask you to reschedule your appointment. ***If your HMO or managed health care plan determines that your office visit (or procedure if performed) is not a covered service (e.g. cosmetic procedures) and not covered in its plan, please be aware that you are responsible for the fee, and will be billed accordingly.***

MANY PLANS HAVE HIGH DEDUCTIBLES/ COINSURANCES. YOU ARE RESPONSIBLE FOR PAYING THESE CHARGES IN FULL.

You will be held responsible for any remaining balance not covered by your insurance. Our billing service sends out bills on a monthly basis. Please do not ignore these bills. If the billing cycle is complete, and payment is not received, we will then employ the use of a collection agency. You agree to be responsible for all costs of collection, including court cost and collection agency and/or legal fees.

If you receive a bill that you question, please call our Billing Service at 1-888-245-5337. Although we participate in most insurance plans, we recognize that many of our patients either have no insurance, or carry health insurance with which we do not participate. We truly appreciate your interest and loyalty, and try our best to make office visits affordable.

A = DIPLOMATE, AMERICAN BOARD OF DERMATOLOGY

B = CERTIFICATION IN PEDIATRIC DERMATOLOGY, AMERICAN BOARD OF DERMATOLOGY

C = CERTIFICATION IN DERMATOPATHOLOGY, AMERICAN BOARDS OF DERMATOLOGY AND PATHOLOGY

GARDEN STATE COMMUNITY MEDICAL CENTER ● ONE HUNDRED BRICK ROAD, SUITE 306 ● MARLTON, NEW JERSEY 08053 ● (856) 596-0111 ● FAX (856) 596-7194

COOPER UNIVERSITY HOSPITAL ● THREE COOPER PLAZA, SUITE 211 ● CAMDEN, NEW JERSEY 08103 ● (856) 342-2381 ● FAX (856) 968-8454

We do not participate in workmen's compensation cases.

We have provided a summary of our most often used charges.

- An average **new** patient office visit charge is between: **$100-$250.**
  An average **follow-up** visit charge is between: **$60-$150.**

- **Other charges** may result when biopsies, surgical treatments, or complex medical consultations are performed. For example, our charge for performing one skin biopsy is $155.

- Any specimen that is sent to the lab for pathology will customarily be covered by your existing health insurance. Prescriptions, laboratory tests, and imaging studies would also be covered by your existing health plan.

We understand that economic matters seem to be at the forefront in the 21st century. They are frustrating for patients and physicians alike. If you are having financial difficulty, please discuss it with us. We will work with you to help you through your difficult times in an ethical manner. We will not misrepresent any medical information to ensure reimbursement by insurance companies.

****Friends and colleagues should be aware that we abide by the Kennedy-Kasenbaum law prohibiting physicians from waiving co-payments and deductibles.***

We realize you have many options for dermatologists. We are thankful to those who make Drs. Heymann, Manders, Green, Halpern, Sommer and Julianna Jarvis, PA-C their choice. We look forward to meeting you soon.

CANCELLATION / NO-SHOW POLICY

If it is necessary to cancel an appointment, we require that 24 hour notice be given, otherwise you will be charged a $50.00 fee. We reserve the right to discharge from our practice patients who miss multiple appointments or fail to give 24 hours notice of cancellation.

I hereby consent and authorize Heymann, Manders & Green, LLC (HMG) to release to the Social Security Administration and Centers for Medicare & Medicaid Services, its intermediaries or carriers, and to any other insurance or managed care company covering me or my dependents or insurance beneficiaries, any information, including protected health information, needed for processing of claims for payment for services rendered to me or my dependents or insurance beneficiaries, as applicable. I request that payment of Medicare, insurance or managed care benefits for services rendered to me (or my dependents or insurance beneficiaries, as applicable) be made directly to HMG. I further understand and agree that if my insurance plan sends payment to me rather than HMG, I will immediately endorse the check to HMG and forward it to HMG to be cashed and applied to my account.

Thank you,

Drs. Heymann, Manders, Green, Halpern, and Sommer

Patient signature_____ Date _____