Lisa S. Ball, FNP PLLC
THE NEIMAN DERMATOLOGY BUILDING
1140 Youngs Road, Williamsville, NY 14221
www.NeimanDermatology.com
T: 716.688.0020
F: 716.261.2716

NOTICE OF FINANCIAL RESPONSIBILITY AND WAIVER

Positive verification of your insurance coverage cannot always be made at the time of service. You will receive services with the understanding that in the event your coverage is not in effect or services have been denied for lack of benefits or referral, you may be billed and held financially responsible for the services rendered.

If you have chosen a high deductible plan for your insurance coverage, this means that you must meet a certain, pre-determined amount of out-of-pocket expense before your insurance will cover any of your healthcare costs. After you have met your deductible, you may only be responsible for co-payments. Questions concerning your deductible should be directed to your insurance company as every contract is unique.

You are financially responsible at the time of service for the payment of destruction of benign skin growths such as skin tags, milia, and age spots, because these services are not medically necessary to remove and your medical insurance will not cover services not considered medically necessary. A claim cannot be filed to your insurance company for these services.

Laboratory and specimen fees are dependent on your health insurance. A separate fee could be associated with these services depending on your health insurance coverage.

The service, treatment, or equipment you are receiving probably will not be covered by your health plan because we are a nonparticipating provider with the following insurances:

- Medicaid primary and secondary (20% Coinsurance)
- Fidelis
- WellCare

The total cost of the service, treatment, or equipment is your responsibility.

Returned Checks:
Checks returned for any reason (ie. insufficient funds) will be subject to an additional fee.

No Show Fee:
All appointments that are deemed as a 'no show' will be responsible for a $50 charge to be paid before additional visits will be scheduled.

Cancellation Fee:
All appointments require 24 hour notice to cancel upcoming appointment, if cancelled less than 24 hours a $50 fee will be assessed to patient.

Signing below indicates your understanding of the proceeding information.

_____

I have read the above disclosure and understand my financial responsibility for services rendered. I agree to the above policies.

Printed Name _____

Signature _____

Date _____