DeLuke Dermatology
Dr. Elise DeLuke, M.D.
4949 Main Street
Amherst, NY 14226
Phone (716-970-4140)
Fax (716-970-4676)

PAYMENT POLICY AND FINANCIAL AGREEMENT

Thank you for choosing this facility for your medical care. DeLuke Dermatology's mission is to deliver care with compassion, empathy and respect for each individual's dignity and privacy.

In consideration of the services to be rendered, the Undersigned, agrees to the following provisions of this agreement.

I understand that I am responsible for giving DeLuke Dermatology the correct insurance information at time the services are rendered. DeLuke Dermatology will bill my secondary insurance one time as a courtesy. I certify that all insurance information reported to DeLuke Dermatology for this episode of care includes all available sources of coverage and I assign DeLuke Dermatology the right to receive sufficient monies from said insurance to pay for care and treatment rendered. If payment is not received from my primary or secondary insurance within 45 days of the date of service, the balance becomes my responsibility. All insurance information must be provided to the office at the time of service. I understand that my insurance policy is a contract between me and my insurance company. Regardless of my insurance status, and the assignment of benefits set forth above, I agree that I am ultimately responsible for full payment of the balance on my account for all professional services from the date entered.

Delinquent Payment Policy

I understand that DeLuke Dermatology will aggressively pursue any delinquent payments and will take all steps it deems necessary including, without limitation, obtaining any and all appropriate judgments and/or liens against me. I acknowledge and agree to pay any and all reasonable attorney's fees and collection expenses incurred should my account become delinquent.

Returned Check Fees

Checks returned by the bank, for any reason (i.e. insufficient funds available), are subject to a service fee.

I HAVE READ, UNDERSTAND AND AGREE TO THE APOVE INFORMATION.

_____

Patient and/or Guardian Signature Date

_____

Print Name Relationship (if applicable)