MANHATTAN
DERMATOLOGY

FINANCIAL POLICY

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Payment is expected as services are rendered. We accept cash, Visa, MasterCard, American Express, Discover, and personal checks.

For those patients who are covered by insurance, we will be happy to bill on your behalf, whenever medically applicable, as long as we are a contracted provider with your insurance company. Co-pays will be collected on the day of service. Co-insurance and/or deductibles as specified by your policy will be billed through your insurance company. Tests run in the office or which are referred to an outside facility, such as pathology, laboratory, radiology, or other diagnostic tests may be billed separately and will be in addition to the office visit charges.

Verification of benefits is not a guarantee of coverage. Medical necessity is up to the determination of your insurance provider. You the patient may be responsible for services even if Dr. Magovern is contracted with patient's insurance company.

If we are not a provider, we will collect payment at the end of your visit, and provide a statement for you to submit to your insurance company for direct reimbursement.

Any outstanding balance that is your responsibility will be expected to be paid in full within 30 days of notification.

Thank you,

Dr. Ashley Magovern + Team

I understand that I will be expected to pay for all applicable fees the day of service. I understand that I am responsible for any balances not covered by insurance. I will assume responsibility of notifying this office of any changes in insurance coverage.

I authorize my insurance company to pay directly to Ashley Magovern, MD, or her associates, the amount due in my pending claim for basic medical, major medical or surgical treatment. (If applicable).

I authorize the office of Ashley Magovern, MD, Inc. to release to any company providing me with medical insurance any information, including the diagnosis and the records of all treatments and/or examinations provided to me by Ashley Magovern, MD, Inc. for the purpose of billing. (If applicable).

I agree to this financial policy and I have read and received a copy of this document.

Patient Name: _____

Patient Signature: _____

Date: _____

ASHLEY MAGOVERN, MD
board-certified dermatologist

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