SPRING STREET DERMATOLOGY

75 Spring Street FL2, NY NY 10012

4 West 48th Street NY NY 10019

T: 212-431-4749

F: 917-210-4316

www. spingstderm.com

YOU HAVE A COPAY AND/OR CO-INSURANCE, DEDUCTIBLE BASED PLAN

What this means:

Copay: The amount the patient must pay up front at an office visit.

Co-insurance: A portion of the medical cost the patient must pay after the deductible has been met

Deductible: The amount the patient pays for covered health care services before the insurance plan starts to pay

As of this visit, your deductible could be outstanding.

Your future balance:

With your plan, unless your deductible or out of pocket max has been met for the year, **you will have a balance for this visit.** You will receive a statement in the mail at the address provided, or a link via Klara to pay this balance once the claim is processed. If your copay is $0, we will not collect anything up front today. Regardless of if you have a copay or not, you will be required to leave a card on file. Here's why:

Office visits get billed to your insurance depending on the complexity of the visit and what is done or discussed with the physician. Most balances left to deductible-based plan members start at $250 and go up. Please keep in mind: your balance is due to your insurance, not at the discretion of this practice. We bill at a set rate because we fall under the category of "**Dermatology Specialty/Professional Office.**"

We do not encourage this, but you are free to pay the Selfpay office visit charge of $250, which is a fixed rate (not including procedures). This would all be collected directly after the visit.

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Your signature below indicates that you **fully understand and agree** to the above given information. You understand that you will be responsible for any copay, co-insurance, and deductible owed by you for this visit and any upcoming visits billed to insurance. You consent to leaving a card on file or enrolling in autopay.

If you do not currently have a plan with these requirements (I.e., Medicare or Medicaid), your signature below is in the instance your insurance plan changes and the above would then apply to you.

Name of Patient:

Signature of Patient or Legal Guardian (if patient is a minor):

Date: