Goldstein
Medical and Aesthetic Dermatology

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Dear Patient:

We are pleased to welcome you to our dermatology practice. Our goal is to provide you quality care. We participate in most of the health plans in the area, and therefore would like you to be aware of the following office policies:

Each insurance company has varying rules regarding covered or uncovered services, which laboratories can be used for surgical specimens, number of referrals and procedures when referrals are not obtained.

We would therefore ask you to read the following statements carefully and sign at the bottom, acknowledging that you agree to these provisions:

1. The patient has the obligation to obtain the referral for services from the primary care physician when required.

2. This office is not able to check on availability or validity of referrals and therefore, this responsibility is borne solely by the patient.

3. We use four different laboratories for surgical specimens and lab services – METROWEST MEDICAL CENTER PATHOLOGY LABORATORY, DERMDX NEW ENGLAND, BIO REFERENCE LABORATORIES, and MGH DERMATOPATHOLOGY ASSOCIATES. If any of these laboratories are not covered by your insurance plan, please let us know. In the absence of your informing us of this fact, you will be responsible for all laboratory charges incurred by you if surgical procedures are performed.

4. ***Some surgical procedures are considered cosmetic and are not paid by insurance***. We are in not able to determine which of the procedures are considered cosmetic and there again it is the responsibility of the patient to know if their insurance will not pay. If such uncovered procedures are performed, payment responsibility will be borne by the patient.

5. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, a fee of $50 will be charged for all missed appointments ("No Shows") and appointments which are not cancelled with at least a 24 hour advance notice. If you do not show for your initial visit as a new patient and fail to contact our office you will be charged a $100 fee.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period will result in termination from our practice.

By signing below, you acknowledge that you have received this notice and understand this policy:

Printed Name _____

Signature of Patient or Personal Representative _____

Date _____