Shelley Berson, MD, FAASM, FAAOA
Rockland Ear, Nose and Throat Associates, P.C.
2 Strawtown Road #6, West Nyack, NY 10994
845-727-1340 | 845-727-1349 Fax

CANCELLATION POLICY

Please be aware that if an appointment is not cancelled at least 24 hours in advance, you will be charged a fee of **$25.00**.

This fee is not covered by your insurance company. Thank you for your cooperation.

Signature _____ Date _____

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PAYMENT POLICIES

As a courtesy to you, our office employs a billing company and participates with several insurance carriers. Every program is different. Please familiarize yourself with your insurance's practices and policies, including authorizations and lab facility requirements.

1. If your insurance carrier requires you to pay a portion of your healthcare visits (copays, deductibles), we are legally required to collect these. No exceptions will be made. You are required to pay your copay at the time of your visit.
2. If your insurance carrier requires you to have a referral, please provide a valid, active and timely referral or you will not be seen.
3. If your insurance company requires you to meet an annual deductible before your healthcare fees will be covered by them, you will be billed for the services rendered if you have not met that deductible.
4. I acknowledge receipt of this information _____.
5. You will be asked to leave a credit/debit card number at the time of check in. This information will be held securely until your insurances have paid their portion and notified us of your personal remaining balance. At that time this remaining balance owed by you will be charged to your credit card and a copy of the charge will be mailed to you. We will make every effort to contact you before processing the charge.

I _____ authorize Rockland Ear, Nose and Throat Associates, P.C., to charge outstanding balances to the following credit card:

Discover (Account/Exp. Date) _____

MasterCard (Account/Exp. Date) _____

Visa (Account/Exp. Date) _____

HSA (Account/Exp. Date) _____

Name on card _____

Signature_____ Date_____

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MEDICARE PATIENTS ONLY

Name of Patient _____ Health Insurance Claim # _____

I request that payment of authorized Medigap/supplemental benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to:

Name of Medigap Insurance _____

any information needed to determine these benefits payable for related services.

Patient Signature _____ Date _____