

**HARRIS R. STERMAN, MD**  
PLASTIC AND RECONSTRUCTIVE SURGERY  
870 PALISADE AVENUE SUITE 203  
TEANECK, NEW JERSEY 07666  
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201-836-3571 fax

## **OUR FINANCIAL POLICY**

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

**PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR.**

**WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD (S) FOR YOUR FILE.**

**THERE IS A \$25.00 FINANCIAL CHARGE FOR RETURNED CHECKS.**

**A COLLECTION FEE OF 25% WILL BE ADDED IF THIS ACCOUNT IS SENT TO OUR COLLECTION AGENCY.**

\*COPAYMENTS - By law we MUST collect your carrier designated copay at the time of service. Please be prepared to pay the copay at each visit.

\*NON COPAY PLANS – If your plan does not require a copay and we participate, we will accept the designated fee. You are responsible for any deductible and balance your plan indicates on their explanation of benefits.

\*MEDICARE – We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the 20% co-insurance, which will be billed to secondary insurance if you have one.

\*MEDICAID – We **DO NOT** participate with Medicaid or other related insurance plans. Financial arrangements must be made at the time of visit.

**YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.**

**PLEASE BE ADVISED THAT THE OFFICE ONLY PARTICIPATES WITH MEDICARE.**

**IF YOU RECEIVE PAYMENT FOR SERVICES RENDERED YOU MUST NOTIFY THE OFFICE IMMEDIATELY AND THE CHECK MUST BE FORWARDED TO US WITHIN 7 DAYS, OTHERWISE YOU AGREE TO BE RESPONSIBLE FOR THE ENTIRE FEE SUBMITTED BY DR. STERMAN**

**I HAVE READ AND UNDERSTOOD OUR FINANCIAL POLICY.**

PRINT PATIENT NAME \_\_\_\_\_

RESPONSIBLE PARTY SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_