Stony Brook Medicine

LONG ISLAND ALLERGY AND ASTHMA

DIANE H. CYMERMAN, MD

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A LOCATION OF STONY BROOK INTERNISTS

NAME & DATE: _____

OFFICE POLICY:

In order to avoid any billing misunderstandings, please read the following information and initial the following. Your initials signifies your understanding and willingness to comply with office policy.

Insurance Co-payments and Deductibles:

Payment is required for all services at the time they are rendered. All applicable co-payments, deductibles and previous balances will be collected prior to services rendered. There will be a $25.00 fee for all returned checks. In the event that your account must be turned over for collections, interest and/or a collection fee at the provider's current rate may be charged on all balances that are past due.
Initials X _____

Referral Information:

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and to assure referral is available and valid at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral, the expiration date of my referral, and obtain new referrals as needed. If a referral is not valid for a visit that I am seen, I may be billed in full for that visit.
Initials X _____

Insurance:

I understand I am responsible for notifying Dr. Cymerman's office prior to my visit of any changes in my insurance or contact information. I will be responsible for payment in full for visit if I do not notify the office of changes in insurance in a timely manner that affects bill.
Initials X _____

Cancellation Policy:
Should you be unable to keep your appointment, kindly contact our office as soon as possible to cancel your appointment. Failure to contact the office with at least 24 hours notice will result in a $75.00 fee. This fee is not reimbursable by your insurance company.
Initials X _____