THE MEDICAL GROUP OF NEW JERSEY
NAVESINK DERMATOLOGY

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Financial Policy

Effective Date: June 8, 2026

We are committed to providing high-quality dermatologic care while maintaining clear and transparent financial practices. This policy explains your financial responsibilities. By receiving services, you agree to these terms.

1. Usual, Customary, and Reasonable (UCR) Fee Schedule

Our practice maintains a single master UCR fee schedule of standard charges for all services. These charges are used for all insurance billing and reflect the full value of services provided. We update fees periodically based on market data, costs, and Medicare benchmarks.

2. Insurance Participation and Billing

- We participate with many insurance plans. It is your responsibility to verify your coverage, benefits, deductibles, copays, coinsurance, and any referral/authorization requirements before your visit.

- We will bill participating (in-network) insurers as a courtesy. You are responsible for all patient portions (deductibles, copays, coinsurance, non-covered services) at the time of service or upon receipt of statement.

- Non-Covered or Denied Services: You are responsible for full payment of any services not covered or denied by your insurer.

3. Out-of-Network (Non-Participating) Insurance

For plans where we are out-of-network:

- We will bill your insurance as a courtesy using our full UCR charges.

- Your insurer may reimburse at a lower rate (often based on their UCR or a percentage of Medicare). You are responsible for the full balance, including any difference (balance billing), where permitted by law.

- We recommend contacting your insurer for estimated benefits prior to services.

- We comply with all applicable federal and New Jersey laws regarding billing transparency and patient protections against surprise medical bills.

4. Self-Pay / Uninsured / Prompt-Pay Discount Policy

- Eligibility: This discount applies primarily to uninsured patients (those without any applicable health insurance coverage for the service) or patients who formally elect to be treated as self-pay.

- Uninsured/self-pay patients who pay in full at the time of service qualify for a prompt-pay discount off our standard UCR charges. Specific discounted fees for common services (e.g., E/M visits, biopsies, destructions, excisions, pathology) are available upon request.

- This discount reflects administrative savings from no insurance billing or collections.

- Insured Patients Electing Self-Pay: Patients with insurance who wish to forgo filing a claim must obtain pre-approval from the practice and sign a written Self-Pay Election/Waiver form acknowledging full financial responsibility and restricting insurance billing. Approval is at the practice's discretion and subject to applicable payer and Medicare rules.

- Good Faith Estimates: For uninsured or self-pay patients, we will provide a written good faith estimate of expected charges upon scheduling (or upon request), in compliance with the No Surprises Act.

5. Payment Requirements and Methods

- Payment for patient responsibility is due at the time of service unless other arrangements are made.

- Accepted forms: Cash, check, credit/debit card, HSA/FSA. Returned checks may be subject to a $35 service fee.

- For scheduled procedures or high-balance visits, a deposit or full estimated payment may be required in advance.

6. Additional Policies

- Missed Appointments/Cancellation:
Standard appointments must be canceled by 10:00 am the day prior to your appointment. For Monday appointments, cancellation must be made by 2:00 pm on the Friday preceding your appointment. Failure to do so will result in a $50 no-show/late cancellation fee.

Surgery appointments (excisions and Mohs surgery) require a larger block of time and must be canceled three days in advance. Failure to do so will result in a $100 fee.

The no-show/late cancellation fee will be billed to you directly and is not covered by insurance. We understand that emergencies arise; in these cases, please contact us and speak to our office manager.

- Changes: Fees, policies, and participation lists are subject to change. Current information is available upon request.

We appreciate your understanding and prompt payment, which helps us focus on excellent patient care. This policy complies with applicable federal and New Jersey laws, including the No Surprises Act.

Assignment of Benefits

I hereby assign all medical benefits and insurance payments payable to me under my insurance policy(ies) directly to The Medical Group of New Jersey for services rendered. I authorize The Medical Group of New Jersey to submit claims on my behalf and to receive payment directly from my insurance carrier(s). I understand that I remain financially responsible for any balances not paid by insurance, including deductibles, copayments, coinsurance, and non-covered services.

Patient Acknowledgment

I have received, read, and understand the Financial Policy. I agree to its terms and accept financial responsibility for services provided.

Signature: _____ Date: _____

Patient Name (Printed): _____

Guarantor (if different): _____