Office Financial Policy
Moskowitz Dermatology, M.D., P.L.L.C.
(407)542-0100

Patient Name:_____ Date of Birth:____/____/____

Dear Patient:

Moskowitz Dermatology, M.D., P.L.L.C. participates with many but not all, healthcare plans. Individual and group policies occasionally change. Our practice will continue to file your claims. However it is your responsibility to present a current proof of insurance, ensure we are participating providers, and pay all applicable copayments and deductibles. If we are not listed providers for your plan, your care may still be covered but with a higher deductible. The financial responsibility for service rendered by our providers ultimately rests with the patient for any and all charges not covered by third parties.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in our office.

_____ Date _____

Patient Signature

_____

Parent/Guardian