ADVANCED LASER & SKIN CANCER CENTER, LLC
Gangaram Ragi, M.D., Director
870 Palisade Avenue, Suite 302, Teaneck, NJ 07666 Tel.: (201)836-9696 Fax: (201-836-4716)
Website: www.mohsnj.net

To Our Patients:

In our efforts to go green and keep the cost of healthcare down we have implemented the following policy.

If we are providers for your insurance company, you will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of your financial responsibility. At that time, any remaining balance due to ADVANCED LASER & SKIN CANCER CENTER, LLC will be charged to your credit card. If we are NOT providers for your insurance plan, the office policy remains the same: you will pay in full at the time of your visit. **It is in your best interest to understand your insurance plan.**

This credit card policy will be an advantage to you as you will no longer have to prepare and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and post in the mail. This policy benefits everybody by keeping the cost of healthcare down, and by allowing us to concentrate first and foremost on your medical needs.

Our credit card on account policy in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays, Co-insurances, and deductible amounts will, of course, still be due at the time of your visit.

Please note, any charges over $100 will receive a courtesy call to advise that we will be charging this to your credit card on file.

If you have any questions, please do not hesitate to ask.

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I authorize ADVANCED LASER & SKIN CANCER CENTER, LLC to charge outstanding balances on my account to the following credit card. If the billing address for this credit card differs from your home address, please advise us of the billing address. Thank you.

Visa ___ MC ___ AmEx ___ Discover ____

CC Number _____Exp. Date _____/_____ Security Code __

Name on Card (Print) _____ Primary Phone_____

Patient Name _____ Patient DOB _____

Signature _____ Date _____