

# ELIZABETH A. LIOTTA, MD, LLC

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FREDERICK, MD 21702  
301-668-3004

9711 MEDICAL CENTER DRIVE, SUITE 307  
ROCKVILLE, MD 20850  
301-838-4303

Thank you for choosing us as your health care provider. To ensure that all of our patients are treated fairly and openly, we have instituted the following Patient Policies. **Please read and sign this statement prior to treatment.**

**Unless you are a member of one of our accepted insurance plans or Medicare, full payment is due at the time of service. We accept cash, checks, Visa, or MasterCard.**

**As a patient of Elizabeth A. Liotta, MD, LLC I understand it is my responsibility to:**

- provide accurate and complete information regarding my medical needs, medical history, medications, demographics, and health insurance, and to report any related changes in these areas to the physician and/or staff.
- provide proof of identification (driver's license) and current insurance information prior to or upon arrival for my appointment (parent's information if the patient is a minor).
- provide a valid referral (if required by your insurance company) prior to or at the time service. If a valid referral is not available at the time of my appointment, I may be required to pay the full amount of the visit or reschedule my appointment until a valid referral can be obtained. I may be charged a cancellation fee if my appointment is rescheduled due to the lack of a valid referral.
- provide 24 hours notice when canceling an appointment (exceptions are made for emergencies). I understand that I may be charged a cancellation fee if I do not provide 24 hours notice.

**I further understand the following policies of Elizabeth A. Liotta, MD, LLC:**

- After checking in for a scheduled appointment, should I have to leave before being seen I must notify the reception desk or I may be charged a cancellation fee. If the provider is running more than 45 minutes late, the cancellation fee may be waived, however I still must notify the reception desk that I am leaving.
- Payment on all statements I receive is due upon receipt, and all outstanding balances, insurance deductibles, and co-pays are expected to be paid in full prior to services rendered.
- Any uncollected balances on my account may be referred to an outside agency for collection, and a service charge may be added to my outstanding balance.
- I will be financially responsible for charges incurred for any dermatological procedure deemed as cosmetic by my insurance company.
- I will be charged a medical records copying fee, as allowed by Maryland Law, which must be paid before records are copied and sent.
- A fee of \$30.00 will be imposed for any checks returned due to insufficient funds.

We thank you for taking the time to read and understand these policies, please let us know if you have any questions.

I have read and understand the Patient Policy statement:

\_\_\_\_\_  
Signature of Patient or Responsible Adult

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date