COMPLETE SKIN LA

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FINANCIAL POLICY STATEMENT

Thank you for choosing COMPLETE SKIN L A for your dermatologic cure. In order to minimize confusion and misunderstanding between our patients and the practice, we have adopted the following financial policies. If you have any questions about our policies, please discuss them with one of our staff members. We are dedicated to providing you with the best possible care and service and we regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

General
Your insurance policy is a contract between you and your insurance company only. If you fail to notify our practice of any insurance change(s), you are fully responsible for any amount not paid by your insurance company. Each health plan varies with regard to deductibles, co-payments, and co-insurance. Terms are contracted between the insurance company and the patient at the time you accept the insurance. It is your responsibility to be aware of your deductibles, co-payments, and co-insurance, and it will be your obligation to remit all appropriate payments as outlined in your insurance policy. These policy requirements do not allow our practice to absorb any co-payments, co-insurance, or deductibles.

Insurance Coverage
If you have insurance through a company we have contracted with, we will require a copy of your insurance card and a current/valid driver's license. All co-payments are due prior to seeing the physician on the day of visit. You will responsible for all deductibles, co-insurance, co-payments, and any services denied by your insurance carrier as not medically necessary and/or not covered.

Medicare
Medicare requires that you pay an annual deductible per calendar year. We collect any outstanding deductible due on the day that services are rendered unless your secondary/supplemental carrier pays the Medicare Part B deductible. Please make every effort to know your secondary/supplemental insurance coverage. We will ask you about this during your visit to remind you.

After the deductible is satisfied, Medicare will pay 80% of allowed charges. If you do not have secondary/supplemental coverage, you will be responsible for 20% of those charges on the day the services are rendered.

Medicare does not pay for all outpatient medical costs. By law, we cannot "write off" the difference, therefore, you are responsible to pay us if there is a balance.

Laboratory
You care often requires the use of laboratory studies, imaging studies, or pathology evaluation. These studies are not performed at our practice. If your care does require the use of any of these modalities, you will receive a separate bill from the physician or laboratory providing that specific service. Please understand that we cannot control these costs. If you have any questions regarding these costs, please ask your physician prior to your procedure.

Our Hope
We want to provide you with the best care possible. In the current economic climate, your resources are especially valuable. It is our experience that informed patients are better able to allocate their resources in a way that is comfortable for them. Hopefully, this letter will help you to achieve the goal of being better informed.

Self-Pay Patients (Will Pay)
For patients with no insurance, the guarantor is responsible for the bill at the time of service.

Cosmetic Patients
Cosmetic procedures will not be submitted to your insurance company. Payment is due at the time of service.

Minor Patients
For all services tendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred during the visit.

Payments
Payments can be made, by cash, check, VISA, or MasterCard. Patient balances are due immediately upon receipt of statement.

Returned Checks and Collections
A charge of $35 will be applied for all returned checks. In the event that any action is brought to collection, I agree to pay any reasonable collection costs and/or attorney fees. My signature below indicates my understanding and full responsibility for the balance on my account for any professional services rendered at COMPLET SKIN L A

I have read and fully understand all of the information above.

Printed Name (First, Middle Last):_____ Signature: _____

Date:_____ Social Security #: _____

Benefits Assignment
I hereby authorize the assignment of benefits (payments) directly to COMPLETE SKIN L A, MIRA STOTLAND, M.D. for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-payments, deductibles, and non-covered services are due in full at the time of service.

Signature of Responsible Party: _____ Date:_____

Records Release
I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: _____ Date:_____