Pacific Dermatology INSTITUTE

Pacific Plastic Surgery and LASER CENTER

Date: _____

FINANCIAL AGREEMENT

Thank you for choosing our practice for your skin care needs. We are pleased to welcome you to our practice. Our chief concern is that you and your family receive the finest care in maintaining healthy skin. Please be advised that you, the patient, are responsible to understand the insurance plan you have selected and meet all requirements to fulfill contractual agreements between your plan and our practice. If you feel you are unaware of your plans co-pays, deductibles or co-insurance, we ask that you to kindly reschedule your appointment until you completely understand your financial responsibility.

We will be glad to submit your claims to your insurance carrier for payment, however the final responsibility of payment due for services rendered is yours, the patient or the guarantor. Prior authorization does not guarantee payment of services and if a referral is required from your insurance carrier, medical group or primary care physician, you will be responsible for obtaining one prior to your visit. The Patient is responsible for all charges not paid by the insurance company. At time of visit, please present all necessary information to avoid non-payment by the insurance carrier, which includes the insured party's information, current insurance card(s), any required insurance referral and accurate completion of the registration paperwork.

If we do not participate with your insurance carrier, payment is due at time of service. We require a 48 hour notice of cancellation of your surgery or cosmetic appointment and 24 hour notice for all consultations and follow ups. Otherwise you will be subject to a missed appointment fee of $50 for Surgery and Cosmetic Appointments and $25 fee for all consultation and follow up appointments.

Please note that some procedures may be deemed not medically necessary or cosmetic and not payable by your insurance carrier. A provider or staff member will notify you of your financial responsibility before performing such procedure.

All Pathology diagnostic testing are billed separately and are the responsibility of the patient. Our staff will do its best to identify which lab your insurance plan or medical group is contracted with. Please ensure you present the correct information to identify the proper handling of any testing.

We accept payment in the form of cash, check or credit card. Returned checks are subject to a $25.00 service charge and any cancelation of product will incur a 20% fee.

If we are a participating provider with your insurance company, we are contracted to adjust your account by a certain amount which is known as a "contractual write-off". This does not mean you will not have a balance. We will bill you for money directed by your insurance company. If your account goes into "collections", in addition to your outstanding balance, you will be responsible to pay 25% fee charged by the collection agency as well as any legal or court costs as specified by our collection agency.

Administrative fees:

Any medical necessity forms/letters required by your insurance company or any communication outside the usual and customary forms required for billing or communication with other physicians or provider, will be subject to a $25.00 administrative fee. We will be happy to complete your disability forms which are subject to a $25.00 fee. As a courtesy to our patients relocating out of the area, we will be happy to supply your new dermatologist a copy of your medical records at no charge. Any other requests for copies of medical records will be subject to 10 cents per page fee.

We understand that occasionally some of our patients will experience financial difficulties. It is our hope that you will bring these situations to the attention of our billing department or office manager to allow us to help manage your account in the most effective way.

Further I, the undersigned, authorize release of medical information to referring providers, consultants and my insurance company for any legitimate healthcare services. I authorize benefits and payment to Pacific Dermatology Institute or the provider.

_____	_____	_____
Signature of Patient or Guardian	Print Name	Date