SANTA MONICA DERMATOLOGY
OFFICE FINANCIAL POLICY AND CONSENT FOR DISCLOSURE

Thank you for selecting Santa Monica Dermatology Medical Group for your medical care. We look forward to assisting you with your healthcare needs. In order to prevent any misunderstanding concerning your medical care, including the responsibility for payment, please read and sign this agreement prior to treatment.

FINANCIAL POLICY

1. **Insurance.** You must provide proof of insurance at the time of your initial visit, or any time you have a change in coverage. If you do not provide us with your current insurance card, you will be considered a cash patient and you will be responsible for full payment at time of service. If you provide proof at a later time, and within the timeline of your insurance company, we will bill your insurance and reimburse you any applicable amount as determined by your insurance. We participate in many insurance plans, including Medicare.
2. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage and to confirm the physician whom you are seeing is contracted.
3. **Co-payments and deductibles.** We cannot waive copays and deductibles. You are responsible for any coinsurance, copays, deductibles, and non-covered services as required by your insurance carrier.
4. **No Insurance.** Payment will be due and payable at the time of service.
5. **Cosmetic procedures.** Payment is due and payable at the time of service.
6. **HMO Coverage. We do not accept HMO insurance.** If this is your only coverage, payment is due and payable at time of service.
7. **Referred services.** If you are referred to another medical provider for specialized care, please be advised that such medical provider may have financial policies that differ from ours. Billing for medical services rendered by referred physicians, or labs (such as for a second pathology opinion) will be billed and handled by that provider. They may not be contracted with your insurance. The labs and Pathologists to whom we refer provide us trusted and expedient results.

Summary. If problems arise regarding insurance coverage issues, we will work with you to help resolve them. However, please be advised that you are nevertheless ultimately financially responsible for payment of medical services rendered in this office. Please feel free to discuss any financial concerns and cost of medical services before services are provided.

Acknowledgment –notice of Privacy Practices. I hereby acknowledge receipt of Santa Monica Dermatology's privacy practices. This notice provides detailed information about how the practice may use and disclose my confidential health information. I understand that Santa Monica Dermatology has reserved the right to change its privacy practices that are described in the notice. I understand that a copy of any Revised Notice will be provided and made available to me upon request.

ASSIGNMENT:

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THE FINANCIAL POLICIES OF THIS MEDICAL OFFICE. I ALSO AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THIS OFFICE. I FURTHER AUTHORIZE THE RELEASE OF INFORMATION REQUIRED TO PROCESS AN INSURANCE CLAIM AND TO CARRY OUT TREATMENT.

Signature:_____

Name:_____

Date:_____