



SKIN CARE AND LASER
PHYSICIANS OF BEVERLY HILLS
GENERAL AND COSMETIC DERMATOLOGY

Welcome

Please read and sign the following statement and let us know if you have any questions. Thank you.

FINANCIAL POLICY – Payment is due in full at the time of service. We accept cash, checks, Visa, MasterCard, and American Express. Under no circumstances will cosmetic procedures be billed to your insurance plan. UCLA Department of Pathology/Cedars Sinai Laboratory Services will bill you and/or your insurance plan directly for laboratory services rendered (blood work, cultures, biopsy specimens, etc).

If we are unable to confirm your insurance benefits or if your deductible has not been met, a \$95 deposit will be required for the initial office visit. Insurance co-payments are due at the time of service; we are contractually obligated to collect co-payments/co-insurance required by your plan. This does not include the cost of any procedures. Please note that your insurance plan ultimately determines your financial responsibility; any additional amount due will be billed to you after your insurance company makes this determination.

As a courtesy, we will submit insurance claims directly to any PPO insurance carrier regardless of the physicians preferred provider status. We will not submit claims to any HMO plans. Our physicians are preferred providers for most of the following plans. **Please be advised that there are differences in our physicians preferred provider status.**

Aetna/Prudential
Beech Street/Capp Care
Blue Cross
Blue Shield
CCN

Cigna
Health Net
Medicare
Multi-Plan
One Health Plan

PacifiCare of California
Principle Financial Group
United Health Care

It is **your responsibility** to be aware of any restrictions, limitations, and requirements outlined by your insurance policy. If pre-authorization is required, you are responsible for coordinating all arrangements with your primary care physician, medical group, or insurance representative prior to your appointment. In the event that we have not received payment and/or correspondence from your insurance carrier within six weeks of filing a claim, you may receive a statement for the outstanding balance. We will appreciate any assistance you can provide to expedite insurance reimbursement.

APPOINTMENT POLICY - If you need to reschedule or cancel an appointment, please notify us at least 48 hours in advance or you may be subject to a \$50 LATE CANCELLATION fee. This policy applies to appointments with the doctors, registered nurse, and esthetician.

Assignment of Benefits and Authorization to Release Records – My signature below indicates that I hereby request payment of benefits for all medical services provided by my physician be issued directly to him. I accept full financial responsibility for all expenses incurred and agree that any portion not paid by my insurance is due and payable from me upon demand. I grant authorization to release any information required to obtain payment of medical benefits.

My signature below indicates that I have read and understand this statement in its entirety and that my questions have been adequately answered.

Signature

Date