comprehensive dermatology
OF LONG BEACH

FINANCIAL POLICY

Thank you for choosing our Office. We are committed to the success of your treatment. Accurate information and prompt payment will allow us to continue giving you the best possible care.

A. If you DO NOT have insurance coverage, full payment is due at the time services are rendered.
B. If you have insurance coverage:
    1) You must provide current, accurate health insurance information at the time of service. Claims that are denied due to inaccurate insurance information will become the patient's responsibility.
    2) We will be glad to bill a maximum of (2) insurance companies.
    3) It is your responsibility to know your insurance plan and to verify coverage for other doctors, recommended tests, and laboratory work. We will bill your insurance Company, however, any co-payment, co-insurance and or deductible are due at the time of your visit. If insurance does not pay within 45 days, you will be responsible for the bill.
    4) A $10.00 service charge may be applied to patient account balances not paid within 30 days of receipt of our billing statement.
    5) If you fail to make payment in full for the services that are rendered to you, your outstanding balance (over 60 days) may be sent to a collection agency. In addition, you will be solely responsible for the fees assessed by the collection agency.
C. Regardless of your insurance coverage, you are ultimately responsible for full and timely payment of all charges incurred in our practice.
D. Our practice is committed to your health care, and we ask that you do the same. A $150 re-booking fee will be charged if you cancel or not show to your appointment without a 24-hour notice.
E. Some cosmetic procedures like (Fraxel, Accure, Ablative C02, RF microneedling and the Cool Peel) require a 50% deposit at the time the appointment is made. The balance will be due 24 hours prior to cosmetic procedures.

We accept cash, check, and all major credit cards.

Please sign that you have read and agreed to this financial policy.

_____ _____

Signature of patient or responsible party Date signed

_____ _____

Print patient name Print responsible party name

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