THE DERMATOLOGY CENTER at Ladera

Financial and Care Consent Agreement

Patient Information			
Patient Name (first, middle initial, last)			Date of Birth (MM/DD/YYYY)
Address	City	State	Zip
Cell Phone	Home Phone	Email	

Please list any contacts with whom we can discuss the patient's care/emergencies/finances in detail (e.g., spouse, parent, child, etc.):		
Contact Name	Relationship to Patient	Phone Number
Contact Name	Relationship to Patient	Phone Number

Insurance Information	❑ Or, Check Here if Self-Pay (e.g., no insurance, HMO benefits only, Kaiser, etc.)	
Primary Insurance	Subscriber/ID#	
Subscriber Name (if not the patient)	Relationship to Patient	Date of Birth

Secondary/Supplemental Insurance	Subscriber/ID#	
Subscriber Name (if not the patient)	Relationship to Patient	Date of Birth

Patient Responsibilities and Practice Policies:

Consent to Treatment. I authorize The Dermatology Center at Ladera and its affiliated providers and staff (the practice) to perform any diagnostic or therapeutic measures as indicated for my health, or per my request to improve my skin conditions.

Taking an Active Role in My Care. I am responsible for scheduling, attending, or rescheduling appointments as necessary, following up on test and biopsy results, and notifying my doctor if I choose not to follow the recommended treatment plan. If I fail to follow the recommended care plan, I absolve my providers, staff, and the practice of any resulting responsibility.

Protection of Health Information. My health information may be released for healthcare operations including care and payment coordination and related activities. Additional releases require explicit consent. I may receive detailed messages containing health information via text, voice, or other methods. The Notice of Privacy Practices is available upon request.

Understanding my network, benefits, and plan limitations. Coverage and payment for services depends on my plan, regardless of my doctor's assessment of medical necessity, and the practice cannot guarantee the outcome of medical claims processing. Preventative visits, which are typically reserved for Primary Care Providers, will not be billed. I am ultimately responsible for all charges, including if my insurance denies coverage for any reason; this includes the practice's failure to identify out-of-network plans. The practice is In-Network with most full-network/traditional PPO plans and publishes its best understanding of network participation on its website. **The practice is out-of-network with:** United Healthcare PPO, all HMO/IPA plans (including Medicare Advantage HMOs), Medicaid/Medi-Cal/CalOptima, Worker's Compensation, most State Exchange plans, most Narrow Network PPOs, and most Blue Shield and Anthem Blue Cross individual/family plans purchased outside of

employer group plans. I am encouraged to verify with my insurance if my plan includes my doctor at this practice and what cost-share may apply, prior to my appointment(s). I authorize my insurance to pay the practice directly.

Bring Insurance Card to every visit. I am fully responsible for keeping my insurance records up to date with the practice, including notifying them immediately of any changes, and for any charges related to uncollectable claims due to delays or inaccuracies. Failure to do so will result in self-pay status. Providing the practice with my insurance information does not confirm in-network status.

Additional Fees for Procedures and Tests. Co-pays usually apply to office visits and typically do not cover procedures or treatments (e.g. freeze, removal, injection, etc.). Procedures are not guaranteed to be effective and often require multiple sessions, each with separate fees. Medical procedure estimates are generally not provided by the doctor when billing insurance; estimates can be given, but procedures may need to be rescheduled. Additional fees may apply for phone, virtual, prolonged, or follow-up visits, complications after treatment, coordination with other providers, or special care. Any tissue removed incurs biopsy and pathology fees. Pathology consults or other tests may need to be ordered through independent sources to complete a diagnosis. Contact those facilities directly for billing inquiries.

Co-Pay, Self-Pay, and Cosmetic services are due at the time of service. Co-Pays that must be billed after the date of service incur a $5 billing fee. I may be asked for payment towards my coinsurance or deductible prior to treatment. Cosmetic consults have a $200 fee, and cosmetic procedures often require a deposit. If a cosmetic visit turns into a medical visit, both medical and cosmetic charges will apply.

Billing & Financial Responsibility. The practice is obligated to collect my full cost share, including co-pay, co-insurance, and deductible. Past due balances incur a $10 fee for each additional statement, and a $35 fee is charged for returned checks. Delinquent payments may be subject to 18% interest (or the maximum allowed by law), and accounts 30 days overdue will have any self-pay, out-of-network, or courtesy adjustments rescinded. Collections activity by the practice for overdue balances will have added fees of 50% of charges or more, and my family and I will be discharged from the practice.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

Cancellation Fees. I agree to cancel appointments at least one full business day in advance. Late cancellations and no-shows will incur a fee of $50 for a regular appointment, $100 for procedures, or loss of any required deposit.

Agreement. I have read, understand, and agree to these terms and conditions. If signing as a Parent/Guardian, I accept responsibility on behalf of the patient.

✘ _____ _____

*Signature of Patient **(or Parent/Guardian)*** *Date*

If signing as a Parent/Guardian:

_____ _____ _____

Printed Name *Relationship to Patient* *Date of Birth (MM/DD/YYYY)*