HUNTINGTON DERMATOLOGY GROUP
800 South Fairmount Ave., Suite 425
Pasadena, CA 91105
Ph (626)449-9992
Fx (626)449-4504

OFFICE FINANCIAL POLICY

Patient Name:____ Date of Birth:_______

Dear Patient:
We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

MEDICARE

We are Medicare participating providers. We will bill Medicare carriers. You will be responsible at the time of service for payment of:

- The annual deductibles
- Copayments
- Charges for noncovered or cosmetic services*
- You will be asked to sign a Advanced Notice of Liability Form in the event that a service is provided which we know is not covered by Medicare.

If you have Medicare, as well as a secondary coverage with a commercial plan, we will file a claim to your secondary /supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.

NON-MEDICARE/ COMMERCIAL PLANS

If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both you primary and secondary insurance plans for contracted plans. **You will be responsible at the time of service for payment of:**

- The annual deductibles (**If you only have primary insurance and no secondary, you will be required to pay 50% of the entire bill)**
- Copayments
- Charges for noncovered or cosmetic services

In the event that you, as the patient, or we, as the physicians, are not aware of a change that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier. Please be aware that you may still be billed for any remaining balances or amount not collected at the time your services are rendered. **Services rendered at the time of service are covered based on medical necessity, but are not a guarantee of payment.**

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

____ ____________________
Patient Signature **Date**