

**Advanced Dermatology of San Clemente, Inc.**  
675 Camino De Los Mares, Suite 400, San Clemente, CA 92673 Ph.949-248-4547  
**ASSIGNMENT OF RIGHTS AND BENEFITS\***

I hereby assign all rights and benefits under my contract with my insurance company to Advanced Dermatology, Inc. for the purposes of determining the details of the benefits of my policy and obtaining payment or services given.

The assignment further permits Advanced Dermatology Inc. to obtain from my insurance all information necessary for the determination of benefits allowed under the contract and permits the direct disclosure to Advanced Dermatology Inc. of all information including benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered.

A photocopy of this assignment shall be considered as effective and valid as the original.  
I understand that my insurance carrier may disallow certain diagnoses or services as medically uncovered, medically unnecessary or cosmetic. I agree to be responsible for payment of all such services rendered to me or my dependents.

I also understand that my insurance policy is a contract between my insurance company and me. If my insurance company does not pay my claim within 30 days after it is received, I agree to remit payment to Advanced Dermatology Inc. within 2 weeks of receiving the bill, and contact my insurance company regarding this settlement. Advanced Dermatology Inc. and her staff will assist me in processing my claim; however, I am ultimately responsible for payment of my account. Late payments may result in a \$15 late fee.

I am responsible for understanding my own insurance coverage. I know that it is impossible for Advanced Dermatology Inc. and staff to know everything about each individual's coverage. Any price quotes are an estimate based on average treatments and fee schedules from the insurance companies. They are an effort to help me make medical and financial decisions about my care. They are not considered binding.

A \$20.00 fee will be charged for each insufficient funds check returned.

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Patient /Guardian Name *Print*    Date                      Patient/Guardian *Signature*

**NOTICE TO MY PATIENTS**

**New Regulation — Medical Board Of California  
Mandated by Business and Professions code section 138  
Effective June 27, 2010**

**Dear Patients:**

**Please be informed that I am licensed and regulated by the:**

**Medical Board of California  
(800) 633-2322  
www.mbc.ca.gov**

**Your signature and date acknowledges you have been informed and understand. Thank you in advance for your time and effort in completing this important paperwork.**

**Patient's/Representative Signature** \_\_\_\_\_ **Date** \_\_\_\_\_