

Advanced Dermatology of San Clemente, Inc.

675 Camino De Los Mares, Suite 400

San Clemente, CA 92673

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.

Responsible Party/Patient Name
(Please Print)

Date

Patient/Guardian Signature

* Assignment means, "to give." This form means you are giving this office full authorization to act on your behalf in obtaining and collecting money for your health care at this office. You are still responsible for the full payment of your care including the annual deductible, co-payments, and any amounts the insurance company will not pay. We will be happy to bill your insurance company for your care, but even though you have insurance, please remember it is your personal bill.