Treatment And Financial Responsibility Agreement

Assignment of Benefits:

I hereby give authorization for payment of insurance benefits to be made directly to Michelle Fiore, M.D., a Medical Group, for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this health provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Appointments and Insurance Cards:

When you arrive, please stop at the check in window and let the office staff know you are here before being seated. If you are a new patient or have new insurance you must present it before being seen otherwise it will be changed to a self pay visit.

Cancellation Policy:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit. Please help us accommodate you and our other patients by giving us 24 hour notice if you cannot keep you appointment to avoid a $50 charge that is not covered by your insurance.

Patient with Insurance:

Although we will bill your insurance company/medical group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty days of billing your insurance company/medical group, we will contact you for assistance. Should your insurance company/medical group deny coverage for any reason, you will be responsible for payment in full within thirty days of your billing statement.

Dual Coverage:

Fiore Dermatology abides by the California State Insurance laws, which govern coordination of benefits. Therefore, you are responsible for providing us with all billing information for primary, secondary and tertiary insurance plans.

Co-Pay Policy:

If your insurance has a co-pay, they require that you pay the co-pay at the time of the visit. A co-pay is collected for all office visits including visits with the doctor or other medical staff.

Patients Without Insurance:

Our fees cannot always be determined in advance, since they depend on the services rendered. You will need to pay the charges at the time of services.

Misc. Fees:

Our fee for copying medical records and completion of forms such as disability forms, family leave, airline cancellation, etc. is $25.

Anesthetic Cream for Procedures:

Our fee for anesthetic cream for numbing of an area prior to procedure is not covered by insurance and costs $10-$25 depending on the area covered.

Returned Check:

There is a $30 service fee for all returned checks.

We are here to help:

Please call if you have any questions. Office: (650)591-8501

I have read and understand the above policies and I agree to comply with them. I attest that all information given is true and accurate to the best of my knowledge.

Patient Signature:_____Date:_____

Printed Name:_____