SANTA MONICA DERMATOLOGY GROUP
2001 SANTA MONICA BLVD, SUITE 990W
SANTA MONICA CALIFORNIA 90404

OFFICE FINANCIAL AGREEMENT

Dear Patient:

With all of the recent changes in insurance policies and plans, we have found a lot of misinformation and disinformation from the insurance companies regarding plans and coverage. We have discovered that even though we have been participating providers, there are now plans from the same insurance companies which do not consider us a participating provider. In addition, standard insurance industry policies make a disclaimer that any benefit quoted over the phone or website is not a guarantee that services provided are covered, and each individual's coverage benefits are determined at the time of processing the claim.

We will send a claim to your insurance company for all services provided by our office. However, you are responsible for confirming that your particular plan considers us a participating provider. **You will be responsible for all deductibles, copays, and any balance due not paid by your insurance company.**

Please sign below to acknowledge receipt of this information and agreement.

Patient Name:_________________________________

Signature:_____________________________________ Date:_________________________