Pacific DERMATOLOGY & COSMETIC LASER CENTER

DR DOUGLAS M KEEL
OFFICE 858.535.1400
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Financial Policy

Dear Patient,

Welcome to our office. We appreciate the opportunity to provide you the best of service. Our office is dedicated to excellence in patient care, and in order to maintain our high standards, we believe it is important that we communicate our policies to you up front. Should you have any questions, our office staff and Dr. Keel are happy to help you.

1. Payment is due at the time of service. We accept cash, checks, Visa, MasterCard, and AMEX. Insurance cards and proof of identity are required to be presented before every visit.

2. **In-Network Services:** We have made prior arrangements with many insurance companies and other health plans to accept payment for services. At this time we provide in-network services for Aetna PPO, Anthem Blue Cross PPO, Blue Shield PPO, United Healthcare PPO, Healthnet PPO, Cigna PPO and Medicare among others. We will bill them, and you are required to pay a co-payment at the time of your visit. **Please be advised that it is your responsibility to ensure we are In-Network at the time of your visit and you are responsible for any deductible that has not been met. We do not take HMO insurance.**

3. **Out-of-Network Services:** If you are insured by a PPO plan that we do not have a prior arrangement with, the fees will be processed as out-of-network. We will prepare and send the claim for you but many times you will pay higher than in-network fees for our services. **Please be advised that you are responsible for all fees at the time of service or billing. HMO insurance is not accepted and will be treated as Self-Pay.**

4. Not all insurance plans cover all services and fees. In the event your insurance plan determines a service to be "cosmetic" or "not covered," **you will be responsible for the complete charge**. Payment is due upon receipt of a statement from our office. All cosmetic services are to be paid in full at the time of service.

5. Upon receipt of payment from your insurance company, we will adjust our fees and bill you for the remaining balance. This amount is often your unmet deductible or copay. If the amount due is over 90 days, a final notice for payment will be sent to you. If payment is not received within 30 days of your final notice, a collection agency will be will be employed to collect the balance due. This may adversely affect your credit. A $50.00 fee will be charged for any returned checks.

I hereby assign payment directly to Douglas M. Keel, D.O., Inc. for all benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all the charges whether or not they are paid by insurance.** I have read and understand the practice's financial policy and I agree to be bound by its terms. I am aware that services are provided exclusively by Douglas M. Keel, D.O., Inc., doing business as Pacific Dermatology & Cosmetic Laser Center. I hereby authorize the doctor to release any information necessary to secure the payment of benefits. I also understand that it is my responsibility to make sure that the bill is paid in a reasonable time. If for any reason any portion of the bill is not paid by my insurance within thirty days from the date of service, I agree to make arrangements for prompt payment.

By signing below I have read and understand the practice's financial policy and I agree to be bound by its terms.

X _____ _____ _____

Signature of Patient (or guardian if patient is under 18) | **Relationship to Patient (if signed by guardian)** | **Date**

X _____

Please print the name of the patient