Integrated Dermatology of Mission Viejo, APMC
26691 Plaza, Ste 230, Mission Viejo, CA 92691-6300
Tel 949-364-2904
Fax 949-364-2909

Billing and Payment Agreement

I, _____, agreed to the following terms:
Please print name here or place identification sticker

1. For those with medical insurance, I understand that my medical insurance will be billed for all medical services provided by this office. I also understand that I am responsible for all copays, co-insurance payments, deductibles, and all services not covered by my insurance. Furthermore, I understand that it is my responsibility to know the details of my insurance plan including but not limited to copays, co-insurance, and deductibles.

2. For members of Optum (formerly Monarch Healthcare) but without Medi-Cal coverage, I understand that treatment of benign lesions such as but not limited to skin tags and seborrheic keratosis are NOT covered medical services. I will be responsible for their treatment payment.

3. For those not members of Optum, I confirm that I am NOT receiving any medical coverage through Medi-Cal. If it is determined later that I am receiving Medi-Cal benefit, I understand that this office will NOT bill Medi-Cal on my behalf and that I will be responsible for the payment of all services provided by this office.

4. For those without insurance, I understand that the minimal office payment per visit will be **$175.00** and that any additional procedure done will be charged separately.

5. I understand that it is my responsibility to provide correction information regarding my identification, insurance, and medical coverage eligibility. I understand that I am responsible for all financial charges and fees as result of incorrection information.

By signing below, I acknowledge that I have read and understand the terms and conditions listed above. This consent will remain effective from the signing date until a written notice to terminate this consent has been received.

Patient Signature _____ Date _____
or Guardian/Legal representative for patient *m/d/yyyy*

For signee who is NOT the patient please fill below:

Name _____ Relationship to Patient _____
Please print name here