SkinPhysicians & Surgeons
859 E. Foothill Blvd., Suite B, Upland, CA 91786 (909)981-8929

FINANCIAL AGREEMENT

I understand that as a courtesy, SkinPhysicians & Surgeons will be happy to file my insurance claim for covered services rendered at this office. I understand that I am personally responsible for charges incurred for medical care rendered by SkinPhysicians & Surgeons. Medicare, insurance companies, my employer, and others (collectively "Payors") may have restrictions on reimbursement for medical care and these may include the need for authorizations or referrals, the use of designated facilities or laboratories, non-covered services, deductibles, co-payments and other requirements. I understand that I am responsible for any charges not reimbursed by Payors. By signing below, I authorize payment of medical benefits by my Payors to SkinPhysicans & Surgeons Medical Group, Inc. for medical services that I or my dependents receive at this office.

I understand that it is solely my responsibility to determine if SkinPhysicians & Surgeons is a preferred provider for my particular insurance plan. SkinPhysicians & Surgeons is a preferred provider for most PPO plans, unions, and Medicare. They are not providers for Medi-Cal or HMO insurance plans. If I do not have insurance, the services rendered are non-covered or "cosmetic" in nature, or my insurance is not accepted here, I will be responsible for all charges incurred.

I certify that all information given by me to bill Medicare, insurance companies, and other Payors is correct, complete, and up to date. I understand that it is my responsibility to notify SkinPhysicians & Surgeons of a change in my address or any change to my medical insurance policy or carrier. I understand that Payors may have time limits for filing claims and providing incorrect and/or incomplete information may result in denial of reimbursement for which I will be personally responsible. I understand that if I have an outstanding bill and fail to notify SkinPhysicians & Surgeons of an address change, my account will likely end up in collections if they are unable to locate me.

I understand that SkinPhysicians & Surgeons has a cancellation policy. If I am unable to keep my appointment, I will cancel my appointment at least 24 hours in advance to allow that time to be filled by someone else with an urgent need to see the doctor. I understand that if I fail to appear for my scheduled appointment, or fail to give a 24-hour notice of cancellation prior to my appointment, my account will be charged $35 for the missed appointment. This policy ultimately allows our office to serve its clientele more efficiently by keeping appointments as readily available as possible. Unfortunately, this is a necessary evil that we have tried in vain to avoid, but one that your courtesy will prevent from ever being an issue for you.

I acknowledge that I understand all of the above and agree to abide by the terms of this document.

_____ _____

Signature (self/parent/guardian) Date

Jeffrey C. Rebish, M.D. Sandra S. Lee, M.D.