San Diego Dermatology & Laser Surgery
12395 El Camino Real, Suite 207
San Diego, CA 92130
Dr. Jason Lupton

FINANCIAL POLICY

The following information is provided so that you understand your financial responsibility when seeking services at San Diego Dermatology & Laser Surgery.

Financial Responsibility: The payment for service provided by San Diego Dermatology & Laser Surgery is your (guarantor's if you are a minor child) responsibility.

Cash and Cosmetic: Cash and cosmetic services are paid in advance. We accept cash, cashiers check, check and credit or debit card.

Insurance: As a courtesy to you, we can file an insurance claim with you primary insurance. Whether we participate with your plan or not, you are responsible at the time of service for payment of:

- The annual deductibles
- Co-payments
- Charges for cash, non-covered and cosmetic services

Each insurance plan is different and we encourage you to read you plan carefully. Eligibility is not a guarantee of payment by your insurance plan. San Diego Dermatology & Laser Surgery gives no assurance that your insurance will pay for all or any part of your services. Medical insurance is a contract between you and the insurance company.

We do not bill cash or cosmetic procedures to insurance carriers.

You will be asked to sign a Waiver of Liability Form in the event that a service is provided which we know is not covered by Medicare, your insurance plan or is designated as cosmetic. If you are a Medicare patient, you will be asked to sign an Advance Beneficiary Notice (ABN) as required by Medicare.

No Show Policy: San Diego Dermatology & Laser Surgery charges a no show fee of $100 to all patients who repeatedly do not show up for their appointment and do not notify the office 48 hours in advance. After three no show appointments you will be required to secure any future appointments with a non-refundable fee of $200.

Your signature below confirms that you have read and understand our financial policy and our no show policy. You agree to abide by the policy and fulfill your responsibility under this agreement.

____

Patient name

____

Parent/Guardian Signature Date