FINANCIAL POLICY

Delphine J. Lee, M.D., Ph.D., INC.
2121 Santa Monica Boulevard
Santa Monica, CA 90404

We, at the offices of Delphine J. Lee, MD, PhD, INC., are committed to providing you with the best possible care. If you have medical insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy. We will submit your claims for Dr. Lee's services to your insurance company on your behalf. You will be responsible for deductibles, co-payments, and all other charges, which are not covered by your insurance. It is essential that you make us aware of any changes in your name, address, phone number, employment, and insurance coverage by calling our billing office, StatMedical, at 818-907-7828.

YOUR HEALTH INSURANCE

By making an appointment with Dr. Lee, you understand and affirm that you were aware before securing your first appointment with her, that she is not a preferred provider (aka not an IN-NETWORK provider) for any insurance other than Medicare. **You affirm you know that you may receive dermatological services from an IN-NETWORK provider, through your health insurance carrier.** It is imperative that you are aware of your insurance policy coverage. Your insurance provider may **require pre-authorization** for office visits, treatment, outpatient procedures, surgery, and in-patient admissions. When a **procedure is recommended**, you are responsible to contact your insurance company if you are unaware of the need for prior approval to ensure coverage of the procedure. If your insurance requires pre-authorization and it is not obtained, you will have **higher out-of-pocket expenses to pay**. Estimated costs for simple routine visits are approximately $200-340 and more complex visits or additional procedures may cost up to $300-$800. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to call our billing office at 818-907-7828 between the hours of 8:30 AM – 4:30 PM, Monday thru Friday (PST). We are here to assist you and we appreciate your cooperation. For patients whose accounts become delinquent and/or balance is sent to a collections agency, the billing office may discontinue the courtesy claim submission to your insurance company and instead, require payment in advance prior to providing another appointment with Dr. Lee.

_____ Please **initial** to indicate that you are aware your insurance policy may have In-network providers available, yet, you are choosing to have Dr. Lee consult and treat even though she is an Out-of-Network provider and you agree with this policy.

We are Medicare providers and will submit claims seeing Dr. Lee on your behalf. Medicare recipients are responsible for their annual deductible and 20% co-insurance. If you have supplemental insurance, we will be happy to bill it for you as long as you provide us with the correct form(s) and billing information.

If you live outside the State of California or in a foreign country, we require pre-payment for a detailed office visit prior to the time of service. If other arrangements are needed, you must contact our billing office in advance to make alternative financial arrangements. If you are a self-paid patient, we require payment in full, at the time of service. We accept MasterCard, Discover, and VISA credit cards. If other arrangements are needed, you must contact our billing office in advance to make alternative financial arrangements.

ADDITIONAL SERVICES

Dr. Lee also provides the option of Phone and On-line consultations if appropriate, for your convenience. Your insurance company may not cover this service.

_____ Please **initial** to indicate that you would like to opt-in for this service.

FOR INSURANCE BILLING:

I hereby authorize the offices of Delphine J. Lee, MD, PhD, INC to furnish my insurance company with all information, which the company may request concerning my present illness or injury. I hereby assign to the offices of Delphine J. Lee, MD, PhD, INC, all money to which I am entitled for medical expenses relative to the service(s) reported. I understand that I am financially responsible to said physician for charges not covered by this assignment. I also understand that Dr. Lee is an out-of-network provider for any health insurance other than Medicare and I accept responsibility for any charges beyond my insurance company's/companies' accepted rates.

Name (printed) Signature Date & Time