The Vitiligo and Pigmentation Institute of Southern California

5670 Wilshire Blvd. Suite 650 ▪ Los Angeles, CA 90036 ▪ **Phone** (323) 467-4389 ▪ **FAX** (323)467-4488

OFFICE POLICIES

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize The Vitiligo and Pigmentation Institute of Southern California to provide medical care and treatment, and to release my medical information to my insurance company (ies) as necessary for payment of benefits. I authorize my insurance company (ies) to pay benefits directly to The Vitiligo and Pigmentation Institute of Southern California. These authorizations remain valid and effective from the date of signing until revoked in writing.

LABORATORY / PATHOLOGY FEES & TEST RESULTS

As a part of your treatment, it may be necessary to have blood tests or a biopsy performed. **All blood and biopsy specimens are sent to outside laboratories for testing and analysis.** You will receive a **SEPARATE** bill from the lab performing the tests, and their fees are **in addition** to those charged by Dr. Grimes/VPI. Please notify the office immediately if you have questions regarding fees or services.

All results of lab work performed in our office will be mailed to you within two weeks of their completion. Notes and explanation of results by Dr. Grimes will be included. If any of the results indicate that there is a need to address them immediately, we will call you. If you have additional questions about your results, please call us.

If you do not receive your lab results in the two week period, please call us at (323)467-4389

PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstandings between our patients and the practice, we have adopted the following financial policy. If you have questions about the policy, please discuss them with our Front Office Supervisor prior to treatment. We are dedicated to providing the best possible care and service to you, and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Your insurance policy is a contract between you and your insurance company only. If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.
- If you have insurance coverage with a plan that we do not have a prior agreement with, we will prepare and send the claim for you. **Therefore, our charges for your care and treatment are due at the time of service.**
- Unless either you or your health coverage carrier have made other arrangements in advance, payment is due at the time of service. For your convenience, we accept cash, check and Credit Cards. If you have a financial hardship, please make us aware of it prior to your receiving services. CARE Credit is a financing option, ask us for an application for their independent program.
- All health plans are not the same and do not cover the same services. In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge for that service.
- For all services rendered to minor patients, we will hold the parent/guardian responsible for expenses incurred.
- In order to provide the best possible service and availability to all of our patients, a 24 hour cancellation notice is required. In the event of a scheduling change by our office, we will make every effort to give you the same 24 hour notice when at all possible.
- Patient balances are due within 30 days of receipt of statement. There will be a $25 charge on any outstanding balance if payment if not received in thirty(30) days unless previous arrangements have been made in advance with our Billing Office.
- Laboratory Fees - Depending on your insurance carriers policy, you may be required to pay a separate co-payment for an specimen taken during your visit.

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval or the service or authorization has been denied, you are fully responsible for all charges that your insurance company does not agree to pay. If addition you will be responsible for all deductibles, co-insurance, co-payments, and any service that your insurance company has determined not to be medically necessary.

I have read and understand the information above. I understand that my insurance company may deny coverage, and I agree to be personally and fully responsible for all charges.

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Patient or Guarantor	Print Name	Date
______________________	______________________	______________________
Witness	Print Name	Date