ADVANCED DERMATOLOGY

ASSIGNMENT OF RIGHTS AND BENEFITS

I hereby assign all rights and benefits under my contract with my insurance company to Advanced Dermatology, Inc. for the purposes of determining the details of the benefits of my policy and obtaining payment or services given.

The assignment further permits Advanced Dermatology Inc. to obtain from my insurance all information necessary for the determination of benefits allowed under the contract and permits the direct disclosure to Advanced Dermatology Inc. of all information including benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered.

A photocopy of this assignment shall be considered as effective and valid as the original.
I understand that my insurance carrier may disallow certain diagnoses or services as medically uncovered, medically unnecessary or cosmetic. I agree to be responsible for payment of all such services rendered to me or my dependents.

I also understand that my insurance policy is a contract between my insurance company and me. If my insurance company does not pay my claim within 30 days after it is received, I agree to remit payment to Advanced Dermatology Inc. within 2 weeks of receiving the bill, and contact my insurance company regarding this settlement.
Advanced Dermatology Inc. and her staff will assist me in processing my claim; however, I am ultimately responsible for payment of my account. Late payments may result in a $15 late fee. A $20.00 fee will be charged for each insufficient funds check returned.

I am responsible for understanding my own insurance coverage. I know that it is impossible for Advanced Dermatology Inc. and staff to know everything about each individual's coverage. Any price quotes are an estimate based on average treatments and fee schedules from the insurance companies. They are an effort to help me make medical and financial decisions about my care. They are not considered binding.

_____ _____ _____
Print Patient /Guardian Name Date ***Signature*** Patient/Guardian

PATIENT'S RESPONSIBILITY FOR CALLING RE. LABORATORY RESULTS

At Advanced Dermatology, we believe it is important that you receive all laboratory results including biopsy results, blood work, and culture results in a timely manner. It is standard procedure for our office to notify our patients by either phone or mail regardless of the results. However, in the unlikely event that you have not been informed of your results, we ask that you call our office to follow up.

By signing below, I acknowledge that I am taking responsibility for calling the office to follow up on my laboratory results in the unlikely event that I have not been notified of them in a timely manner. For example, within two weeks for biopsy results, and one week for blood work and culture results.

As always, your health care is our number one priority and we thank you for partnering with us in your care.

_____ _____ _____
Print Patient /Guardian Name Date ***Signature*** Patient/Guardian

NOTICE TO MY PATIENTS
New Regulation — Medical Board Of California
Mandated by Business and Professions code section 138
Effective June 27, 2010

Dear Patients:

Please be informed that I am licensed and regulated by the:

Medical Board of California
(800) 633-2322
www.mbc.ca.gov

Your signature and date acknowledges you have been informed and understand. Thank you in advance for your time and effort in completing this important paperwork.

Patient's/Representative Signature_____ Date_____

Maryam Moinfar, MD · Jeffrey Lander, MD, PhD · Mahsa Abdollahi, MD
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