Dermatology Associates of the South Bay (DASB)

Amber A. Kyle, M.D. / Krishna Patel PA-C

TERMS & POLICIES - MEDICAL SERVICES

We thank you for choosing us as your Medical & Cosmetic Dermatology provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. If at any time you have questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our Office Manager.

Initials_____	**CANCELLATION/NO SHOW POLICY** Please cancel at least 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to notify our office in advance, you may incur a charge. For example, 30 min appointments/Excisions have a $40 No-Show/Same Day cancellation fee. All MOHS appointments have an $80 NO-Show/Same-Day cancellation fee.
Initials_____	**OFFICE POLICY ON OUTSTANDING BALANCES** Upon an office visit, if you have an outstanding balance totaling $75 or more (and the balance is 4 months or older), you are responsible to pay the balance at the time of your visit. If you cannot pay the entire balance, you will be considered a "cash" patient and will be responsible to pay cash/credit at the time of the office visit. (You can submit a Superbill to insurance to seek reimbursement).
Initials_____	**SKIN CARE SERVICES, SUN EXPOSURE AND PROCEDURE PREPARATION** Please do your best to avoid sun exposure on the day of your treatment, and in many cases a day or more before treatment. Please see our Pre & Post instructions on our website under our Cosmetic Services Tab, (www.SouthBaySkinDoctor.com) and come prepared to your appointment. Many procedures cannot be completed with excessive sun exposure.
Initials:____	**FINANCIAL POLICY / INSURANCE** Payment is expected when services are rendered for cosmetic or non-insurance visits. We accept cash, Visa, MasterCard, AMEX, Discover and personal checks. For those patients who may be covered by insurance, we will be happy to bill on your behalf, whenever medically applicable, as-long-as we are a contracted provider with your insurance company. Co-pays will be collected on the day of service. Co-insurance/or deductibles as specified by your policy will be billed accordingly. It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges or to be seen as a "cash" patient. When insurance is involved, we are contractually obligated to collect co-payments, coinsurance, and deductibles, as outlined by your insurance carrier. Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you are responsible for all out-of-pocket (and out of network) fees. If we are not contracted with your carrier we cannot negotiate reduced fees with your carrier. Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service. We ask that you are familiar with your Insurance plan and coverage prior to your first office visit with us.

Initials: ___	REFUNDS & GIFT CERTIFICATES **Retail**: If you experience a reaction to any products or receive a damaged retail item purchased at our office, please let us know immediately and bring back the item. If returned due to reaction or product defect within 60 days, you can receive a refund. If returned due to reaction or product defect after 60 days, you could replace the item with another product. No other refunding is applicable to retail items. **Gift Certificates**: No refunds, or dollar value given to the recipient.
Initials:____	**RUNNING LATE?** We are very sorry as we understand traffic can be a problem, or things come up which make us late to our appointment. If you can, please call us to inform the Front Office. At that time we will determine if you should continue to the practice for your appointment. However, out of respect to the next patient, if you are 10 minutes or more late, we may have to reschedule your appointment. Thank You for understanding
Initials_____-_____	**TIMELINESS OF APPOINTMENTS (ON OUR PART)** We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.
Initials_____	**MEDICAL RECORDS** Our patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. You may incur a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries.
Initials_____	**PHOTOGRAPHY**- DR Kyle's office is committed to providing high-quality healthcare to our patients. As such, the use of clinical photography for our patients may be appropriate for the diagnosis, treatment of medical conditions as well as professional education (internally only), and cosmetically for Before and After. Use of photography will be carefully controlled and executed in compliance with all state and federal regulations. Clinical photography does not include Patients (or parents or any other outside source), therefore; no one may take photos or videos on their own devices. This is not allowed and failure to comply with this request may result in the termination of the patient care treatment/procedure immediately.

By my signature, I acknowledge that I have read, I understand, and agree to the terms and policies as defined by, DASB.

If desired, I have been given a copy of this notice.

Signature: _____ Date: _____

Revised: 11/30/21