Aesthetic Dermatology & Laser Center
MEDICAL GROUP INC.
www.wonderfulskin.com

Edward M. Kramer, M.D.
Jeffrey M. Hick, M.D.
DIPLOMATES, AMERICAN BOARD OF DERMATOLOGY
Lauren Balbas, PA-C
Julie M. Kramer, PA-C

3055 W. Orange Avenue, Suite 207
Anaheim, CA 92804 (714) 229-8246

27995 Greenfield Drive, Suite C
Laguna Niguel, CA 92677 (949) 360-4400

Dear Patient:

The billing department at Aesthetic Dermatology & Laser Center Medical Group Inc., will bill claims for services rendered as a courtesy. The following are the established guidelines that will be followed in resolving your claim.

1. **Private Pay/ Cash:** We do not participate in any HMO-type insurance plans. If you are unsure of your type of insurance, you are responsible for payment in full at the time of service.

   Pt's Initials

   _____

2. **Commercial/ PPO/EPO/ POS Ins:** Any co-payments, deductible, non-covered services or amounts in excess of lifetime maximum are due and payable at time of service with the entire balance due and payable within thirty (30) days from initial billing date.

   Pt's Initials

   _____

3. **Medicare:** Any deductible or non-covered services are due and payable at time of service with the entire balance due and payable within thirty (30) days from initial billings.

   Pt's Initials

   _____

Patients not confirming prior authorization and/or requesting services when authorization has been denied or has not been obtained will be billed as private pay account and must adhere to the guidelines stated above in the Private Pay section.

Accounts not resolved within forty-five (45) days may be referred to an outside agency for further follow up, reported to the local credit-reporting bureau, and may result in legal proceedings. Please call Customer Service at (714) 229-8246 to make payment arrangements.

An administrative fee of $50.00 will be charged for appointments cancelled without a 24 hour notice.

My signature below acknowledges that I understand my financial responsibility.

_____ _____
Patient/Guarantor Witness

_____ _____
Date Date

PATIENT INFORMATION Date _____

Patient's Name _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Last First Middle

Address _____
Street City State Zip

Birth Date ____/____/____ Age _____ Sex (M/F) _____ Driver's License # _____

Social Security #_____Home Phone ( ) _____

Occupation:_____ Cell Phone ( ) _____ Email Address: _____

How were you referred to our office? _____

Who to notify in case of emergency? _____ Day Phone: _____

INSURANCE INFORMATION

Primary Insurance Carrier _____Primary ID #: _____

Name of Insured_____DOB:_____ Insured S.S.# _____

Secondary Insurance Carrier _____Secondary ID#: _____

Name of insured_____DOB:_____ Insured S.S.#: _____

AUTHORIZATION OF MEDICAL BENEFITS

I hereby authorize the _____ Insurance company to pay by check and mail to: Edward M. Kramer, M.D. Inc., 3055 W. Orange Ave, Suite 207, Anaheim, CA 92804. The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assigned and **I have agreed to pay any balance of said professional service charges, if any, over and above this insurance payment**. I further authorize the release of any medical information necessary to process this claim.

Signed _____ Date _____

May we leave personal medical information on your answering machine at home? ☐ Yes ☐ No

Do you give our office permission to discuss your medical information with family members?

☐ Yes ☐ No If yes, please provide their name and relationship.

Name_____ Relationship_____

Name_____ Relationship_____

I have received a copy of this office's Notice of Privacy Practices (NPP) Pt's Initials_____
I have reviewed a copy of this office's Notice of Privacy Practices (NPP) Pt's Initials_____

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Patient Name: _____ **DOB**: _____

Account #: _____ **Gender**: _____

History:

Allergies to medications: _____

Major problems: Heart _____

High blood pressure _____ Asthma or other respiratory problems _____

Other major problems or illnesses: _____

Is there a family history of skin cancer? _____ or melanoma? _____

Or other major illnesses? _____

Have you ever had skin cancer? _____

List all current medications and topical creams you are using:
_____

Have you ever fainted or been lightheaded when having an injection or surgical procedure?
_____

Do you take antibiotics prior to dental procedures or surgery?
_____

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Aesthetic Dermatology & Laser Center Medical Group Billing Policy

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Due to changes in healthcare that have decreased physician reimbursements and increased the clerical and administrative work required to secure payment for medical services rendered, Aesthetic Dermatology & Laser Center must change its billing policy for the collection of co-payments and payment balances, **effective April 01, 2013.**

Aesthetic Dermatology & Laser Center will no longer send invoices to patients for balances or co-payments. **We will require a credit card to be kept on file.** When the Explanation of Benefits (EOB) paperwork is received from your insurance company, which indicates the amount that the patient is responsible for (i.e. co-insurance, deductibles, etc.), your credit card will be directly charged for those fees. You will ONLY be charged for amounts that your insurance company has determined to be the patient's responsibility.

Another option is for the patient to pay for services rendered at the time of visit by cash, check, or credit card. If and when the insurance company makes its payment to us, a reimbursement will be forwarded to you in a prompt manner.

As a courtesy to our patients, we will continue to bill insurance companies for services provided by our doctors.

Thank you for your understanding and compliance with our office policies.

Sincerely,
The Doctors of Aesthetic Dermatology & Laser Center

AUTHORIZATION TO CHARGE CREDIT CARD

Patient Name: _____ MR# _____

I have read the above policy and authorize Aesthetic Dermatology & Laser Center to keep my signature on file and to charge my credit card for the balance of charges to my account (deductibles, co-payments, and non-covered services) NOT paid by my insurance.

Credit card type: VISA DS MC AMEX Billing Zip Code:_____

Credit Card Number:_____ 3 digit security code:_____

Printed Name on card: _____ Expiration Date:_____

Cardholder's signature: _____ Date:_____

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Pharmacy Update

Effective January 1, 2022

The state of California is requiring all prescriptions to be submitted electronically. Due to this new transition, a paper copy of prescriptions will no longer be provided. Please provide us with your preferred pharmacy below.

Patient Name:_____

Pharmacy Name:_____

Pharmacy Phone Number:_____

Pharmacy Address:_____