

**Michael P. Tabibian, M.D., FAAD**

3801 Katella Avenue, Suite 225  
Los Alamitos, Ca 90720  
562-799-3330

29525 Canwood Street, Suite 220  
Agoura Hills, Ca. 91301  
818-706-3744

Dear Patient,

Since we are responsible for your well-being, we would like to give you some information regarding insurance coverage. There are many different insurance companies and within each company, many different plans, and within each plan, there are several different levels of coverage. Since there is such variety, it would be wise for you to check your specific policy so that you will be aware of what coverage you actually have. After all, you are responsible for knowing your coverage.

It has been our experience that people are often surprised when they learn exactly what their coverage really is. Sometimes certain services are not covered and payment is denied by the insurance company. In most instances, your personal financial responsibility will include payment of your deductible, co-pay, and other amounts specified by your insurance company in a timely manner. We expect full payment of such amounts within thirty days of notification to you. **A \$20 late fee could be added to all accounts thirty days past due, and all accounts 90 days past due will be forwarded to collections with an additional \$35 non-refundable collection fee. Additionally, a \$35 processing fee is added to all checks returned due to insufficient funds or closed accounts.**

We do not and cannot determine our fee schedule based on the abundant number of insurance companies and their varying levels of coverage. Furthermore, we do not want to be involved in disputes between you and your insurance company. By continuing as our patient you agree to pay our fee even though your insurance company may not cover all cost completely.

It is your responsibility to have correct and current insurance information available at the time of your visit; you will need to furnish it promptly or provide payment in full. If insurance information is subsequently provided and results in payment from your insurance company, your payment will be refunded. If your insurance company requests any additional forms or information from you in order to process our claim, we expect that you will comply as quickly as possible. We appreciate your cooperation and understanding in this matter.

**Please be advised that you might receive a separate bill from a Dermatopathologist for second opinions of your biopsy specimen(s).**

I have read the above letter and agree that the payment of these fees is my responsibility.

Printed Name \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

---

**Signature below is only acknowledgement that you have received a copy of our HIPPA Notice Privacy practices which was published and became effective on/before April 14, 2003**

Printed Name \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_