AESTHETIC DERMATOLOGY & COSMETIC SURGERY, INC [ADCS]
INSURANCE POLICY AND
INFORMATION CONCERNING DEDUCTIBLES, CO-PAYS, AND COLLECTION OF BALANCES

This is an agreement between Dr. Jeffrey H. Binstock and Associates and Aesthetic Dermatology and Cosmetic Surgery, Medical Associates, Inc., a California Corporation ("Creditor") and the Patient named hereunder ("Debtor").

In this agreement, the words "you", "your", and "yours", refer to the Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our", refer to Drs. Binstock and Aesthetic Dermatology and Cosmetic Surgery, Medical Associates, Inc.

By executing this agreement, you are agreeing to pay for all services that are received.

1. MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, and new charges to the account, and any payments or credits applied to your account during the month.

2. IF YOU DO NOT HAVE HEALTH INSURANCE, an insurance card, proof of insurance or insurance which does not provide coverage for the services rendered under this agreement, you will be asked to pay for services rendered at the time of visit with cash, check, Visa/Mastercard, or AMX. .

3. IF YOU HAVE HEALTH INSURANCE WITH WHICH WE ARE NOT PARTICIPATING, you may choose to pay by cash, check, AMX, or Visa/Mastercard. We will give you a universal form that you may submit to your insurance company for reimbursement.

4. IF YOU HAVE A COSMETIC PROCEDURE, payment in full is required on or before the day of the procedure. If payment for a cosmetic procedure is not made on or before the day of the procedure, the procedure will be cancelled and will not be rescheduled until payment is received. Liposuction, Fat Transfer, or Blepharoplasty, Accupulse, Fem Touch, etc. are to be paid in full 2 weeks prior to the procedures.

5. IF WE ARE PARTICIPATING PHYSICIANS WITH YOUR INSURANCE COVERAGE, you will be required to pay your prescribed co-payment at the time of your visit. Upon receipt of payment from your insurance company, we will send you an account statement reflecting the status of your account. If your insurance company assigns you additional payments beyond your previously credited payments, this amount will be reflected as an Amount Due and will be due from you immediately upon receipt of your statement. Any disagreement you may have with your insurance company about its additional assignment to you must be negotiated with your insurance company, and does not relieve your obligation to remunerate any and all amounts due to us as reflected on and upon receipt of your account statement.

If your insurance company requires a referral and/or pre-authorization for treatment, you are responsible for obtaining such a document prior to your treatment. Failure to obtain the referral and/or preauthorization may result in a lower payment or no payment from your insurance company, and will consequently increase the amount due from you.

a.) DEDUCTIBLES are that sum of money for services rendered to each patient for medical care in a given year which are approved and allowed by the insurance company, but not paid to the provider, as it is the patient's direct responsibility to pay for the first $200, $400, $1000, etc., depending upon how their policy is written.

b.) For an evaluation and management code, i.e., an office visit, re-visit or consultation, there is a CO-PAYMENT.

c.) For all other services, there is a CO-INSURANCE PAYMENT. For each procedure, the insurance company allows a given amount. The insurance company pays a percentage of the allowed fee, which might be 60% 70%, or 80%. The remainder of the allowed fee is the patient's responsibility. The amount in excess of what the PPO allows is written off by ADCS. It is your discount for using a PPO physician. For specific questions about your insurance policy or your remaining deductible, please call your insurance company, as your policy is personalized to you. Benefits do vary and are out of our control.

6. PAYMENTS: Unless other arrangements are approved by us in writing, the balance of your account is due and payable upon receipt of your statement and is past due if not paid within two (2) weeks of receipt of your statement.

7. FINANCE CHARGE: A finance charge will be imposed upon each item of your account which has not been paid

within thirty (30) days of the time the item was added to the account. The finance charge will be computed at the rate of one percent (1.5%) per month, or an annual rate of eighteen percent (18%). The finance charge on your account is computed by applying the periodic rate (1%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty days prior to the date the statement is issued, and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is $0.50.

8. RETURNED CHECKS: There is a fee of $40.00 for any checks returned by the bank. We reserve the right to increase the returned check fee as necessary, and will inform customers of any increase in writing.

9. MISSED APPOINTMENT FEE: If a patient cancels an appointment with less than twenty-four (24) hours notice, or "no shows" the visit, she/he will be charged a $75.00 fee. The fee must be paid in full before a new appointment may be scheduled.

10. PAST DUE ACCOUNTS: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer the collection to a lawyer, you agree to pay all costs and fees, including but not limited to court costs and attorney's fees, incurred by us in pursuing collection of your account. In case of suit, you agree that venue may be in either Marin, San Francisco or San Mateo County.

11. WAIVER OF CONFIDENTIALITY: You understand and agree that if this account is submitted to an attorney or collection agency for collection of an unpaid balance on your account, if we have to pursue collection in court, or if your past due status is reported to a credit reporting agency, your treatment by our office may become a matter of public record, and any confidentiality shall be waived.

12. IN CASE OF DIVORCE OR SEPARATION: the signator to this financial policy shall remain obligated for payment for all treatment provided to the patient designated herein. The signator shall remain the responsible party unless and until this office notifies you in writing of the cancellation of its financial policy and a new financial policy is executed in behalf of the patient. The execution of a new financial policy shall not relieve the signator to this document of responsibility for any charges to this account made during the time this financial policy remained in effect. In case of divorce or separation, the parent authorizing treatment for a minor child shall remain responsible for all charges to that child's account, even if a divorce decree or other document requires the other, non-authorizing parent shall then be solely responsible for collecting payment or reimbursement from the other parent.

13. CO-SIGNATURE: If this or another Financial Policy relating to the same treatment or patient is signed by another person, that co-signature remains in effect until cancelled in writing, and both co-signators remain jointly and severally responsible for the full amount due on any authorized treatment. Written cancellation of a co-signator's obligation shall become effective immediately and shall apply to any and all subsequent charges to the account. The canceling co-signator's obligation shall become effective immediately and shall apply to any and all subsequent charges to the account. The canceling co-signator shall remain obligated for any and all charges accrued to this account during the time the canceling party was a valid co-signator to the account.

14. EFFECTIVE DATE: This agreement shall become effective on the date signed by the patient or her/his authorized representative(s).

15. We reserve the right to revise or alter this financial policy at all times during the course of your treatment.

DATE:_____ , 202___ . _____
Patient, or Authorized Representative/Relationship

DATE: _____ , 202___ . _____
Witness (AD Inc.) Employee

ACCEPTED BY: Aesthetic Dermatology and Cosmetic Surgery, Inc. REV 3/22