

THE MENKES CLINIC AND SURGERY CENTER

2490 Hospital Drive, Suite 201
Mountain View, CA 94040
(650) 962-4600

The Menkes Clinic and Surgery Center is committed to providing you with the best possible medical care. If you covered by medical insurance, we wish to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our financial policy.

We are contracted with many insurance companies and if you have a question regarding whether or not we are contracted with your plan, please contact your insurance company as they can best answer your questions. **In order to be able to file your insurance claims, we must have a copy of your insurance card. When there is a change in your insurance plan or coverage, please notify us as soon as possible.** Without this information, we will be unable to submit your claim to your insurance for payment.

1. Your insurance coverage is a contract between you and /or your employer, and the insurance company. We are not a party to that contract.
2. As a specialist, some insurance companies require that prior to any visit; you must obtain an authorization or referral from your primary care physician (PCP). If this is not done by the time of your appointment, you will be asked to either reschedule your appointment and contact your PCP, or pay for the services at the time you are seen. Any payments made at the time of service will be promptly refunded upon receipt of payment by the insurance company. Please note that most insurance companies will only cover the cost of the services listed on the authorization or referral. Any services which are not authorized or denied by your insurance company are your responsibility.
3. **Co-payments, if required by your plan, are due at the time of each visit.** Please come prepared to pay the copayment as determined by your insurance plan (most copayments are listed on your insurance card). Most insurance companies require that this amount be paid at the time of service in order to validate the contract.
4. No matter what type of plan you have, HMO, PPO, POS or Indemnity, **it is to your advantage, as well as your responsibility, to know and understand your medical insurance coverage. Not all services are a covered benefit in all contracts.** Contact your insurance company to find out what benefits are covered under your plan.
5. We request that as a courtesy to our other patients, that you **please notify us at least 24 hours in advance if you will be unable to keep your appointment.** We reserve the right to charge for any appointment which is not cancelled with proper notice.

We must emphasize that as medical care providers, our relationship is with you, not with your insurance company. Therefore, all costs for services provided remain the responsibility of the patient/guarantor from the date the service is rendered. We realize that temporary financial problems may affect timely payment in your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account.

All patient balances over 60 days old will be charged 1.5% interest.

I HAVE READ THE ABOVE FINANCIAL ARRANGEMENTS AND INSURANCE STATEMENT AND I REALIZE THAT PAYMENT IS MY OBLIGATION FOR COVERED AND NON-COVERED SERVICES REGARDLESS OF INSURANCE OR THIRD PARTY INVOLVEMENT. I AUTHORIZE THE PHYSICIAN TO FURNISH MY INSURANCE COMPANY WITH ANY INFORMATION REQUIRED AND MY INSURANCE BENEFIT PAYMENTS TO GO TO THE MENKES CLINIC AND SURGERY CENTER.

PATIENT SIGNATURE (guarantor, if patient is a minor)

Date



THE MENKES CLINIC
Medical, Surgical and Cosmetic Dermatology

NOTICE OF PRIVACY PRACTICES

PLEASE READ ENTIRE FORM AND SIGN AT THE BOTTOM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Print Name: _____ Date: ____/____/____

Signature: _____ Tele: (____) _____

If not signed by the patient, please indicate:

- Relationship: Parent or Guardian of Minor Patient
 Guardian or Conservator of an Incompetent Patient
 Beneficiary or Personal Representative of Deceased Patient

Name of Patient: _____



THE MENKES CLINIC

Medical, Surgical and Cosmetic Dermatology

THE MENKES CLINIC AND THE MENKES SURGERY CENTER

Acknowledgement of Receipt of Assurance of Compliance

The Patient's Bill of Rights is emphasized with at The Menkes Clinic and The Menkes Surgery Center. We are dedicated to giving our patients the best care possible while protecting their dignity as human beings. If you feel you or your child are not being treated fairly or properly, you have the right to discuss this with your doctor or nurse.

The Menkes Clinic and Surgery Center comply with the following Federal Acts:

- Title VI of the Civil Rights Act of 1964
- Section 504 of the Rehabilitation Act of 1973
- Title IX of the Education Amendments of 1972
- The Age Discrimination Act of 1975

Specifically, The Menkes Clinic and Surgery Center Assurance Compliance is as follows:

Title VI of the Civil Rights Act of 1964 (Pub. L 88-352), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F. R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the applicant receives Federal financial assistance from the Department.

Section 504 of the Rehabilitation Act of 1973 (Pub. L 93-112), as amended, and all requirements imposed by or pursuant to the regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall solely by reason of his handicap be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant received financial assistance from the Department.

Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant of the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant received Federal financial assistance from the Department.

The Age Discrimination Act of 1975 (Pub. L 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant received Federal financial assistance from the Department.

I here by acknowledge that I received a copy of The Menkes Clinic Assurance Compliance. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy or any amended Assurance Compliance at each appointment.

Print Name: _____ Date: ____/____/____

Signature: _____ Tele: (____) _____

If not signed by the patient, please indicate:

- Relationship: Parent or Guardian of Minor Patient
 Guardian or Conservator of an Incompetent Patient
 Beneficiary or Personal Representative of Deceased Patient

Name of Patient: _____

For complaints or comments about your medical care, you may contact:
Office for Civil Rights, Region IX, U.S. Department of Health and Human Services
50 United Nations Plaza, Room 322, San Francisco, CA 94102
Voice Phone: 415.437.8310
Fax: 437.8329, RDD 415.437.8311