



Dr. Stephen Mandy
South Beach Dermatology

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Dear Patient:

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This letter is to clarify our office policy and your insurance company's policy on cosmetic and noncovered services. Noncovered and cosmetic services are those procedures and services that are deemed by the insurer to be covered under their policy. Your insurance policy specifically states that nonmedically necessary procedures are not covered. This includes the removal of such things as moles, skin tags and other benign growths that are clinically benign and nonirritated. This also includes the removal of "ugly spots" and age-related brown spots, as well as the laser treatment of red spots or broken blood vessels and stretch marks.

Since these procedures are not covered by your insurance, you have many options. The first option is to do nothing. If, however, you wish to have a noncovered procedure done for cosmetic or other reasons, you can have that procedure done in our office or by any other physician you might choose. In either case, the cost will be explained prior to the procedure being done, and you will be asked to sign a disclosure statement.

If tissue is removed, then for protection of our patients, all specimens are sent for dermato-pathologic analysis to our laboratory. Charges for dermatopathology will be billed to insurance but in certain cases, individuals may be responsible for a portion or all of the charges. If the pathology report shows a pre-malignancy or malignancy, showing that the lesion needed to be removed for medical reasons, then we will refund money charges and bill insurance company, (except for necessary deductible and co-payment).

It is very important that you understand your choices so that there is no misunderstanding or confusion. A signed copy of this letter will remain in our chart as proof of this understanding.

**IF YOU WISH TO RECEIVE NONMEDICALLY NECESSARY SERVICES,
PLEASE SIGN BELOW**

I have read the statement above and I understand that I will be responsible to pay full charges for this procedure **today**.

Procedure in Question/Reason

Print Patient Name / Date

Approximate Cost of Procedure

Signature of Patient / Date