JUPITER
DERMATOLOGY &
HAIR RESTORATION
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Hair Loss Evaluation– Appointment & Billing Information

Thank you for your interest in scheduling a consultation for evaluation and management of hair loss. We are pleased to offer this service and want to ensure you have a clear understanding of the **appointment process and associated costs**.

Unfortunately, most insurance plans **do not** cover hair loss treatment as a standard benefit. Insurance may even consider it as cosmetic service. Additionally, many plans may include **exclusions or limitations** that prevent coverage for hair loss-related visits.

Insurance & Self-Pay Policy for Hair Loss Consultations:

- If you **have insurance** (In or Out of Network) we will:
  - Collect a **$350 deposit** at the time of scheduling.
  - **Bill your insurance** for the visit.
  - If the service is **covered**, we will refund any overpayment once your claim is processed.
  - If the service is **not covered or processed as Out of Network**, the $350 deposit will be applied toward the visit cost, and you will not owe more.
- If you are a **self-pay patient** (no insurance), the total cost of the visit is **$350**, due at the time of scheduling.
- Follow up visits for Hair Loss will be **$125.**
- **HairMetrix** analysis included with each assessment.

Preparing for Your Appointment:

- To help us provide the best possible care, please bring the following with you:
  - A list of current medications and supplements
  - Any recent lab work or medical records related to your hair or scalp health
  - A list of hair/scalp products you use
  - (Optional) Photos documenting the progression of hair loss

If you have any questions about the visit, insurance, or payment, please don't hesitate to contact us at 561-748-0510. We look forward to assisting you and appreciate your trust in our care.

Patient Acknowledgment:

By signing below, I confirm that:

- I have read and understand the **financial policy** outlined above.
- I accept full responsibility for the **payment of services** related to my hair loss consultation.
- I understand that **insurance coverage is not guaranteed**, and that I am responsible for payment if the visit is not covered.

Patient Signature: _____

Date: _____