**DIRECT DERMATOLOGY CARE**

**APPLICATION AND AGREEMENT**

**Patient Application and Information**

**Complete for each Patient/Participating Family Member**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient Last Name: | | Patient First Name: | | | MI: |
| Patient Date of Birth: | | Social Security Number: | | | |
| Address: | | | | | |
| City: | State: | | | Zip Code: | |
| Home Phone: | Cell: | | | Sex:  ❑ Male ❑ Female | |
| Email: | | | Marital Status: | | |
| Emergency Contact or Patient’s Guardian: | | | Relationship | | |
| Insurance Information: | | | Policy / Group / ID Number: | | |
| Employer: | | | Work Phone: | | |
| Payment Method: ❑ Check ❑ Credit Card ❑ Cash ❑Automatic Bank Draft  AND are you paying: MONTHLY or ANNUALLY (PLEASE CIRCLE ONE) | | | | | |
| **Start Date of Membership:** | | | | | |

**Patient Certification and Agreement**

|  |
| --- |
| I, the undersigned (the “Patient”), confirm that I have applied to participate in the Renew Dermatology – Direct Dermatology Care Program (as defined below) and that I have read, understand and agree to the attached Renew Dermatology Direct Dermatology Care Terms and Conditions which are incorporated by reference into this Patient Certification and Agreement. **I understand that, once accepted by Renew Dermatology, this Patient Certification and Agreement constitutes my binding agreement to participate in the Renew Dermatology Direct Dermatology Care Program (the “Program”).**  As a condition of my participation in the Program, I certify and agree that:  1. I am not a beneficiary, enrollee, or participant in Medicare, Medicaid, TRICARE, or any other government health care program. If I become a beneficiary, enrollee, or participant in Medicare, Medicaid, TRICARE, or any other governmental health care program, including but not limited to any Medicare managed care program, I will immediately notify Renew Dermatology (the “Practice”) and my participation in the Program will cease effective on the date that I became a beneficiary, enrollee, or participant in the governmental health care program.  2. I have provided full information to the Practice regarding any non-governmental insurance coverage applicable to me and will update the information provided if my insurance coverage changes. I understand that my eligibility for participation in the Program may be affected by the terms and conditions of my insurance policy.  3. I authorize the Practice to bill and collect Participation Fees for myself and all of the Participating Family Members (listed below) as set forth in the Agreement. I understand that I may terminate the Agreement only as provided in Section 10 of the Agreement and that Participation Fees are not refundable. I understand that I am the Responsible Family Member for any individual listed below.  Participating Family Members:  (including yourself)        4. I understand that my participation in the Program is subject to the written approval of the Practice, which may be granted or withheld in its sole discretion. The effective date of any such approval (as set forth below) shall be the effective date of my participation in the Program (“Effective Date”).  5. I UNDERSTAND THAT PARTICIPATION IN THE PRACTICE IS NOT HEALTH INSURANCE AND DOES NOT MEET ANY INDIVIDUAL HEALTH BENEFIT PLAN MANDATE THAT MAY BE REQUIRED BY LAW.  6. I UNDERSTAND THAT, WITH RESPECT TO MY PROGRAM PARTICIPATION, I AM NOT ENTITLED TO HEALTH INSURANCE PROTECTIONS FOR CONSUMERS AS PROVIDED BY COLORADO REVISED STATUTES TITLE 10.  7. I certify that I have made inquiries with my health plan and have confirmed that my participation in the Program does not conflict with my insurance coverage.  Printed Name of Patient:  Signature of Patient or Patient’s Legal Representative:  Date of Signature:  Printed Name of Patient’s Legal Representative (if applicable):  Status of Legal Representative (e.g., parent or guardian):  Program Application Accepted by Practice: Date of Acceptance into Program:    Program Administrator |

**RENEW DERMATOLOGY DIRECT DERMATOLOGY CARE PROGRAM**

**TERMS AND CONDITIONS**

**As a condition to participating in the Direct Dermatology Care Program (the “Program”) offered by Destination Dermatology, LLC doing business as Renew Dermatology (the “Practice”), the Patient agrees as follows:**

**1. The Program is Not an Insurance Policy.**

1. Patient understands that he or she is participating in the Program to receive certain limited health services (the “Program Services” as further defined in Paragraph 6 below).
2. The Program is being offered by the Practice and only applies to Program Services provided at the Practice Location.
3. **Unless the Agreement is terminated as provided herein, Patient is responsible for paying Participation Fees for a minimum period of one (1) year**.
4. Patient understands that the Program is not an insurance plan and participation in the Program should not be considered or used as a substitute for an insurance plan.
5. For questions about the Program, the Practice Location, and/or Program Services please contact the Program Administrator: ***Kelly Ballou, Managing Member, 970-409-4000,*** [***info@renewdermatology.com***](mailto:info@renewdermatology.com)

**2. Definitions. The following definitions apply to the Agreement:**

1. Participating Family Members shall mean all individual Patients who have applied for participation with a Responsible Family Member (as defined below), who are related to the Responsible Family Member as spouse, parent or child, and who reside at the same address as the Responsible Family Member.
2. Responsible Family Member shall mean an individual Patient who has agreed to pay and be financially responsible for all Participation Fees, costs, and expenses and other amounts due to Practice with respect to all of his or her Participating Family Members.
3. Program Administrator shall mean: Kelly Ballou, Managing Member, 970-409-4000. See email address above.
4. Program shall mean the program offered by the Practice to qualified patients under which, upon payment of an established monthly rate, the Patient receives certain Program Services, subject to all of the Terms and Conditions herein.
5. Practice Location shall mean the following: 60 Main Street, Suite H, Frisco, Colorado 80443.
6. Practice Providers shall mean the following Providers: **Kelly Ballou, PA-C**. This list is subject to change from time to time. For up-to-date information, please contact the Program Administrator listed above.
7. Program Services shall have the meaning described in Paragraph 6 below. Program Services shall not include Excluded Services.
8. Excluded Services shall have the meaning set forth in Paragraph 7 below.
9. Participation shall mean a Patient’s privileges to participate in the Program subject to the terms and conditions of the Agreement as set forth herein.
10. Participation Fees shall have the meaning set forth in Paragraph 4 below.
11. Patient shall mean an individual who has been accepted for participation in the Program and who continuously satisfies all conditions of Participation as set forth herein (including but not limited to payment of applicable Participation Fees and other sums due to the Practice) for Excluded Services.

**3. Participation Restrictions.**

1. Participation in the Program is subject to the Patient, or his/her Responsible Family Member, having paid all Participation Fees and other outstanding amounts due to the Practice on a timely basis.
2. Participation is non-transferable.
3. **Persons with Medicare, Medicaid, TRICARE, or other governmental health care program coverage are not eligible to participate in the Program.** Patient shall notify Practice immediately if Patient becomes a beneficiary, enrollee, or participant in Medicaid, Medicare, TRICARE, or any other governmental health care program. Patient’s participation in the Program shall cease effective on the date of his/her enrollment or participation in a governmental health care program.
4. The Participation Application must be approved in writing by the Practice, in its sole discretion, prior to participation in the Program. The effective date of approval shall be the effective date of participation in the Program (the “Effective Date”).
5. Patient agrees to provide full and accurate information to the Practice regarding any non-governmental insurance coverage applicable to Patient (and any Participating Family Member) and will immediately update the information provided if his or her (or a Participating Family Member’s) insurance coverage changes. Patient understands that eligibility for participation in the Program may be affected by the terms and conditions of applicable insurance coverage.

**4. Participation Fees.**

1. Participation Fees may be paid:
2. Monthly OR
3. Annually.

Patient or his or her Responsible Family Member will be responsible for Participation Fees based on the per Patient fee schedule attached as Exhibit A. This fee schedule is subject to change by Practice at any time after the expiration of one year from the Effective Date provided that Practice shall give Patient at least thirty (30) days’ notice of any such change.

b. If paid monthly, Participation Fees will be assessed prospectively on the **20th of each month** due and must be paid by the last day of the month.

c. Patient is solely responsible for payment of all Excluded Services as defined herein. No additional discounts or other Program benefits are applicable to Excluded Services.

d. Practice reserves the right to discontinue services at any time if Participation Fees are not paid when due.

e. Participation Fees are not refundable except when Program participation is terminated in accordance with Section 10(a)(i), Section 10(a)(ii), or Section 10(b)(iii), (v) or (vii) in which case Participation Fees applicable to periods after the effective date of the termination will be refunded to Patient.

f. Any Patient who is a Responsible Family Member shall assume all of the financial responsibilities of his or her Participating Family Members with respect to the Program and shall pay Practice all Participation Fees and other sums due with respect to each of his or her Participating Family Members in accordance with the terms and conditions of this Agreement.

**5. Payment Terms.**

a. Patient understands that his or her Participation Fees must be paid in advance of the applicable payment period.

b. Monthly Participation Fees must be paid on or before the 20th day of each month (the “Due Date”).

c. Patient understands and agrees that any checks, debit or credit transactions or other forms of payment which are not honored by Patient’s bank or other financial institution, due to insufficient funds or for any other reason, will result in an additional fee of $50 per transaction.

d. If the Patient does not pay any Participation Fees by the Due Date for any reason, an additional fee of **$30.00 per month** (the “Late Fees”) will be assessed on a monthly basis until all payments are brought current. The Late Fees are in addition to the Participation Fees due from the Patient. The amount of the Late Fees is subject to change by the Practice at any time.

e. The Practice reserves the right to charge interest at a rate of **eighteen percent (18%) per year, 1.5% per month,** if any payments are not received within thirty calendar days of the Due Date.

f. Invoices over 30 days old will be turned over to collections, and the patient will be subject to an **additional fee of 35%** of the current balance as charged by the collections agency.

g. Patient agrees to pay all costs and fees, including attorneys’ fees and collection fees, in the event that the Practice is required to bring legal action to obtain payment of Participation Fees.

h. Patient understands and agrees that failure to comply with payment terms may result in termination of participation in the Program.

i. Patient understands and agrees that services will not be rendered for patients with any past due accounts.

j. PATIENT AND THE PRACTICE ACKNOWLEDGE AND AGREE THAT (I) SOME OF THE PROGRAM SERVICES MAY BE A COVERED BENEFIT OR PROGRAM SERVICES UNDER PATIENT’S HEALTH BENEFIT PLAN (AS DEFINED IN COLORADO REVISED STATUTES, TITLE 10) AT NO COST TO THE PATIENT; AND (II) THE PRACTICE SHALL NOT SUBMIT A FEE-FOR-SERVICE CLAIM FOR PAYMENT FOR THE PROGRAM SERVICES TO ANY HEALTH PLAN, HEALTH INSURANCE PROVIDER, OR HEALTH INSURANCE ISSUER.

**6. Program Services Included in Participation.**

1. A summary of Program Services is provided in Exhibit B. Patients should check the Practice’s website at www.renewdermatology.com for an up-to-date list of Program Services including the scope of office visits included in Program Services. Changes or reductions in the Program Services available at the Practice may be made in the sole discretion of the Practice.
2. The availability of Program Services is subject to clinical guidelines as well as scheduling and staffing limitations. Appointments for Program Services may or may not be available on a same day basis, depending on scheduling availability.
3. Program Services available under the Program include only a defined set of healthcare services provided by the Practice in the normal course of business. Program Services do not include any of the items or services described below as Excluded Services. Patients should check the Practice’s website at www.renewdermatology.com for an up-to-date list of Excluded Services.
4. For additional information about Covered and Excluded Services, please contact Kelly Ballou, Program Administrator and Managing Member, at 970-409-4000, [info@renewdermatology.com](mailto:info@renewdermatology.com).

**7. Excluded Services.** Exhibit C includes a list of services that areexcluded from the definition of Program Services (“Excluded Services”): This list is summary in nature, may not be all-inclusive, and is subject to modification by Practice. Excluded Services also include the following:

1. Services that the Practice does not customarily provide at the time Patient seeks medical care.
2. Services provided by any health care provider who is not a Practice Provider as defined above.
3. Emergency medical care and services required for the diagnosis or treatment of life threatening events; services or treatment at any facility that is not a Practice facility; diagnostic studies such as outside labs, pathology, and imaging; outpatient pharmacy; any care that a Practice Provider believes is not medically necessary or appropriate; any medical care that a Practice Provider believes should, in the best interest of the Patient, be provided by another facility or provider; or any services for which the patient has coverage under Medicare, Medicaid, or any government health care program;
4. Any Excluded Services listed on the Practice website at **www.renewdermatology.com**.
5. For additional information or questions about Excluded Services, please contact the Program Administrator.

**8. Payment for Excluded Services.** Any Excluded Services received by Patient will be charged and due **ON THE DAY SERVICE IS RECEIVED** at Practice’s applicable fee schedule rates and shall be subject to all of Practice’s financial responsibility and payment policies. Upon request of Patient, Practice may provide a superbill showing the CPT codes for the Excluded Services provided to the Patient and the charges/payments for those services. The superbill may be provided to Patient to send to his or her health insurance carrier at Patient’s sole responsibility and discretion. However, Patient shall be solely responsible for paying practice for all services and charges shown on the superbill. Furthermore, Practice does not guarantee that any Excluded Services which are provided or documented on a superbill will be reimbursable by Patient’s health insurance policy.

**9. Utilization of Services.**

1. In certain situations, Patients may require medical attention including but not limited to: pharmaceutical prescriptions, treatment by a specialist or any health care provider who is not a Practice Provider as defined above, treatment by a hospital, or treatment that is not a Covered Service. These services are Excluded Services (as further defined above) and are NOT covered by the Program. The costs of any Excluded Services are the sole responsibility of the Patient.
2. The Practice reserves the right, in its sole discretion, to cancel the Patient’s participation in the Program for inappropriate use of services, including but not limited to requests for services that are not Program Services.
3. The attending Practice provider will determine the appropriateness of Patient’s visit or request for services.

**10. Termination of Participation.**

a. Patient’s participation in the Program may be terminated by Patient as follows:

1. Patient may cancel participation in the Program within thirty days of the Effective Date (as defined in Paragraph 3.c). **Written notice of cancellation must be provided by certified mail addressed to the Administrator at address documented below in Section 20 and such notice must be received within thirty (30) days of the Effective Date.**  All fees that have been prepaid by Patient for months after the cancellation will be refunded to the Patient.
2. Patient may cancel participation in the Program after Patient has participated in the Program for a minimum of one (1) year provided that Patient gives at least thirty days prior written notice of termination to Practice. The effective date of the termination shall be the first day of the calendar month following the expiration of the thirty (30) day notice given by Patient.
3. Patient may cancel participation in the Program at any time by payment of the following cancellation fee: **sixty-five percent (65%) of remaining balance**.

b. Patient’s Participation in the Program may be terminated by Practice upon the occurrence of any of the following:

1. Patient fails to make payment of any Participation Fees by the applicable Due Date or otherwise fails to comply with his or her financial obligations as set forth in this Agreement.
2. Patient becomes an enrollee, beneficiary or participant in Medicare, Medicaid, TRICARE, or any government health care program (including but not limited to Medicare managed care plans).
3. Practice makes a determination to cancel Patient’s Participation in the Program for any reason including, but not limited to, inappropriate behavior towards any other patients or staff members, repetitive late cancellations, or not showing up for appointments, etc. provided that Practice gives at least thirty days prior written notice of termination to Patient. The effective date of the termination shall be the first day of the calendar month following the expiration of the thirty (30) day notice given by Practice.
4. Patient produces appropriate documentation to show he or she is enrolled in or becomes covered by a health plan that does not permit participation in the Program.
5. Practice discontinues the Program in its sole discretion.
6. Patient provides any false financial or other material information to Practice.
7. Practice determines, in its sole discretion, that there has been a change in applicable law or the interpretation or enforcement of applicable law that may substantially affect the operation of the Program.

c. If Practice terminates Patient’s participation in the Program in accordance with the terms of this Section 10, Practice shall cooperate with the Patient for the transition of care commensurate with applicable standards of professional responsibility within the State of Colorado.

1. Upon termination of Patient’s participation in the Program, Patient will be assessed and shall pay Practice’s full fee schedule charges for any services provided to Patient after the effective date of termination. Additionally, if Practice terminates Patient’s participation for a reason set forth in Section 10.b.(i) above, Patient will be assessed and shall pay Practice’s full fee schedule charges for any services provided to Patient in the one (1) month prior to termination.

**11. Changes in Personal Information.** Patient must inform the Practice immediately of all changes to personal, contact, insurance, billing, and other account information.

**12. Entire Agreement.** The Patient Application and Information, Patient Certification, and Terms and Conditions together constitute the entire agreement (the “Agreement”) between the parties relating to the specific subject matter hereof. There are no terms, obligations, covenants, representatives, statements, or conditions other than those contained herein. No variation or modifications of the Agreement will be deemed valid unless in writing and signed by both parties.

**13. No Waiver.** A written waiver, signed by an authorized representative of the Practice, shall be required to waive any provision, requirement or obligation established by the Agreement between the Parties. The delay or failure of the Practice to require the strict performance of any of the terms or conditions of the Agreement between the Parties shall not be deemed a waiver of any breach or default in the terms or provisions herein. Additionally, a valid written waiver of any breach of the Agreement shall not establish a waiver of any subsequent or different breach of the Agreement.

**14 Assignment.** This Agreement may not be assigned or transferred by the Patient.

**15. Force Majeure.** The Practice is not liable for any delay or failure of performance caused by strikes, insurrection, war, fire, acts of God, natural disasters, electrical failure, black-outs, disruption of transmission lines, government acts or regulations, acts of third parties, or any cause not within the control of the Practice.

**16. Governing Law/Construction.** The validity, construction, and interpretation of the Agreement and the rights and duties of the parties hereto will be governed by the laws of Colorado without regard to choice of law principles. The captions, headings, and paragraph titles in the Agreement are provided for convenience only and shall not be used to interpret, limit, or define the provisions hereof.

**17. Venue.** The exclusive venue for any legal dispute arising out of, or related to this Agreement, will be Summit County, Colorado.

**18. Unenforceable Terms.** If any provision of the Agreement is held invalid, illegal, or unenforceable by a court of competent jurisdiction, the Agreement will be interpreted as if such provision, to the extent the same has been held invalid, illegal, or unenforceable, had never been contained herein.

**19. Successors.** The Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, successors, or executors.

**20. Notices.** Any notice required or allowed to be given by the Agreement shall be addressed to the other party at the address set forth immediately below or to such other address as either party may instruct the other party in writing in accordance with this Section.

|  |  |
| --- | --- |
| **Renew Dermatology:**  ***c/o Kelly Ballou, Program Administrator & Managing Member***  ***265 Dillon Ridge Rd, Suite C402***  ***Dillon, CO 80435*** | **Patient:**  *See address provided in Patient Application Information.* |

**21.** **Arbitration**. Any dispute arising out of, or in connection with, this Agreement or Patient’s participation in the Program shall be resolved by arbitration before one arbitrator selected by the mutual agreement of Patient and the Practice. If Patient and the Practice cannot agree to an arbitrator, the matter shall be submitted to the Summit County District Court in accordance with the Colorado Uniform Arbitration Act. The court shall then select an arbitrator and the arbitration shall be conducted generally in accordance with the then-prevailing appropriate rules of the American Arbitration Association. The award rendered by the arbitrator shall be final and binding. It may be filed with the court of any competent jurisdiction in accordance with applicable law; the court may enter a judgment on this award and that judgment will be enforced as the judgment of the court. In the arbitrator’s sole discretion, a full or partially prevailing party shall be entitled to prompt payment and reimbursement in full for all of its attorneys’ fees and costs relating to the resolution of the dispute.

All items contained above are agreeable by all parties signing below. By signing, all parties have no

questions as to what is written above.

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Participant Signature Date Kelly Ballou Date

Managing Member

Renew Dermatology

**Exhibit A**

**RENEW DERMATOLOGY**

**MEDICAL MEMBERSHIP PROGRAM**

**RE-ENROLLMENT OPTION**

* All Memberships will be initiated with Check, Cash or Credit Card within our office or on our website platform.
* Re-Occurring transactions are made with ACH or EFT payments from Check or Credit Card only.
* All Re-Occurring plans monthly transactions will take place on the 20th of each month or the next business day following the 20th if it falls on a weekend or holiday.

**1 Time New Account Set-Up Fee $79.00**

**Monthly Plans Fees:** **Annual Plan Fees:**

Single Rate $99.00 $990.00

Couples Rate $179.00 $1,790.00

Family Rate (3) Members $259.00 $2,590.00

Family Rate (4) Members $349.00 $3,490.00

Family Rate (5) Members $439.00 $4,390.00

\*Immediate family members only with documentation for proof upon request.

All family members must reside at the same physical address to be included in the membership plan.

**Exhibit B**

**RENEW DERMATOLOGY MEDICAL MEMBERSHIP PROGRAM**

**ALL-INCLUSIVE BENEFITS**

* AS MANY OFFICE VISITS AS NEEDED FOR 1 YEAR
* AS MANY LESIONS TREATED WITH CRYOTHERAPY AS NEEDED IN 1 YEAR
* VERBAL AND WRITTEN EDUCATION AND INSTRUCTIONS ON ANY DERMATOLOGIC CONDITION FOUND
* **2 FREE 3 OZ. BOTTLES OF UV SPORT 50 SPF (WATER RESISTANT X 80 MINUTES) SUNSCREEN PER YEAR PER PERSON INCLUDED IN MEMBERSHIP (1ST BOTTLE GIVEN AT 6 MO. & 2ND BOTTLE AT 1 YR.)**
* AS MANY SKIN TAGS AS NEEDED REMOVED WITH SCISSOR METHOD PER YEAR (LOCAL ANESTHETIC FEE IS EXTRA IF DESIRED)
* WOUND CARE INCLUDING PACKING AND DRESSING CHANGES
* SENDING PRESCRIPTIONS TO PHARMACY
* CANTHACUR APPLICATION FOR VIRAL LESIONS
* COSMETIC CONSULTATIONS (NO TREATMENT INCLUDED) WITH RECOMMENDATIONS FOR INJECTABLES, SKIN CARE PRODUCTS, AND OTHER SERVICES.
* PRODUCT AND MEDICATION SAMPLES AS AVAILABLE.
* COMEDONE EXTRACTION FOR AS MANY LESIONS AS NEEDED PER YEAR

**Exhibit C**

**RENEW DERMATOLOGY**

**DIRECT DERMATOLOGY PROGRAM**

**EXCLUDED SERVICES**

“Excluded Services” are, in general, all services NOT listed in the above Exhibit B titled “RENEW DERMATOLOGY MEDICAL MEMBERSHIP PROGRAM ALL INCLUSIVE BENEFITS.” Such “Excluded Services” include but are not limited to the following:

* Microscopic evaluation (fungal or scabies slides)
* ANY biopsies or lesion excisions (fee for the procedure, lab processing and the pathology reading)
* Mohs’ Micrographic Surgery
* ANY cosmetic or aesthetic services
* Electrodessication and Curettage
* Curettage removal of any lesion
* Intralesional steroid injections
* Incision and drainage
* Any over-the-counter or prescription medications
* In-office products unless specifically listed in the “Renew Dermatology Membership Program Service Level Options” above
* Suture or staple closure

\*\*\*\*PLEASE SEE THE ATTACHED FEE SCHEDULE FOR EXCLUDED SERVICES FOR MEMBERSHIP PATIENTS (BASED ON TIME AND ROUNDED UP TO CLOSEST TIME ALLOTMENT)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |
| **CASH PAY** | | | |  | **MEMBERSHIP** | | | |
|  | **SIMPLE** | **MINOR** | **ADVANCED** |  |  | **SIMPLE** | **MINOR** | **ADVANCED** |
| **TIME** | **SERVICES** | **PROCEDURES** | **PROCEDURES** |  | **TIME** | **SERVICES** | **PROCEDURES** | **PROCEDURES** |
| 10 min | $80.00 | $110.00 | $150.00 |  | 10 min | $68.00 | $93.50 | $127.50 |
| 15 min | $100.00 | $135.00 | $175.00 |  | 15 min | $85.00 | $114.75 | $148.75 |
| 20 min | $130.00 | $155.00 | $210.00 |  | 20 min | $110.50 | $131.75 | $178.50 |
| 25 min | $165.00 | $195.00 | $240.00 |  | 25 min | $140.25 | $165.75 | $204.00 |
| 30 min | $195.00 | $225.00 | $275.00 |  | 30 min | $156.00 | $180.00 | $220.00 |
| 35 min | $230.00 | $255.00 | $310.00 |  | 35 min | $184.00 | $204.00 | $248.00 |
| 40 min | $255.00 | $290.00 | $335.00 |  | 40 min | $204.00 | $232.00 | $268.00 |
| 45 min | $290.00 | $330.00 | $385.00 |  | 45 min | $232.00 | $264.00 | $308.00 |
| 50 min | $335.00 | $365.00 | $420.00 |  | 50 min | $268.00 | $292.00 | $336.00 |
| 55 min | $370.00 | $400.00 | $455.00 |  | 55 min | $296.00 | $320.00 | $364.00 |
| 60 min | $410.00 | $445.00 | $505.00 |  | 60 min | $328.00 | $356.00 | $404.00 |
| 65 min | $445.00 | $485.00 | $545.00 |  | 65 min | $356.00 | $388.00 | $436.00 |
| 70 min | $490.00 | $525.00 | $595.00 |  | 70 min | $392.00 | $420.00 | $476.00 |
| 75 min | $540.00 | $575.00 | $645.00 |  | 75 min | $432.00 | $460.00 | $516.00 |
| 80 min | $590.00 | $615.00 | $685.00 |  | 80 min | $472.00 | $492.00 | $548.00 |
|  |  |  |  |  |  |  |  |  |
| **SET FEES** | |  |  |  | **SET FEES** | |  |  |
| Moh's Surgery | $2,000.00 |  |  |  | Moh's Surgery | $1,750.00 |  |  |
| 2 Layers or less | |  |  |  | 2 Layers or less | |  |  |
|  |  |  |  |  |  |  |  |  |
| Moh's Surgery | $2,750.00 |  |  |  | Moh's Surgery | $2,250.00 |  |  |
| 3 Layers or more | |  |  |  | 3 Layers or more | |  |  |