

## FINANCIAL POLICY

Thank you for choosing us to provide your medical care in the field of Plastic and Reconstructive Surgery. The following is a statement of our financial policy, which we ask that you read, agree to, and sign prior to any treatment.

If reconstructive surgery is planned, our office staff will contact your insurance company to determine eligibility and make certain that benefits are available for your planned surgery. However, even though eligibility has been confirmed with your insurance provider, and pre-certification has been obtained, it is possible for your insurance company to deny benefits after the surgery. For this reason we suggest that you also check with your insurance company.

Your insurance policy is a contract between you and the insurance company. Your insurance may cover none or only a portion of the charges. You should be aware that **you are responsible for the balance of the bill**. If your claim is denied, you are responsible for the entire charge. You as a patient are responsible for all surgical, hospital, lab, or other costs and fees unless you have arranged and confirmed insurance coverage before the operation(s) and your insurance pays for all services.

All elective or cosmetic surgery is payable in advance. Financial arrangements for elective and cosmetic surgery are entirely the patient's responsibility. In certain uncommon circumstances, health insurance companies may pay for some or all of certain types of procedures. If you feel that insurance may help with your medical costs, it is your responsibility to confirm this prior to scheduling your surgery. Regardless of whether insurance is involved, it is the patient's responsibility to pay all costs related to his/her surgery.

Emergency surgery will be handled on an individual basis.

If no insurance is available for reconstructive surgery, payment is expected at the time of the service. For your convenience we accept personal checks, cash, and most major credit cards.

This office takes assignment on Medicare patients as well as the individual contracted insurance companies. A finance charge if 1.5% per month will be added to outstanding accounts that remain unpaid after 60 days.

I hereby agree to full responsibility for all expenses incurred by or on the account of

Patient: \_\_\_\_\_

I authorize my insurance company to pay directly to ARTISTIC PLASTIC SURGERY CENTER, PLLC for services rendered. I agree that I will pay any remaining balance no later than 30 days following the insurance payment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_