



FINANCIAL POLICY

Thank you for choosing us as your surgical care facility. Our goal is to provide you with the highest quality surgical care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- *We may accept any assignable insurance with applicable coverage.*
- *We offer financial assistance (discount, waiver or reduction of deductibles, co-pays and co-insurance) under our indigency policy to all eligible patients on case to case basis.*
- *Full payment is due at time of service unless arranged otherwise.*
- *We accept cash, checks, or Visa/MasterCard and American Express.*
- *We offer extended payment plans with prior credit approval.*

Dishonored checks will be charged back to the patient's account with a service fee of \$25. Dishonored checks not redeemed within 20 working days of written notice to the maker will be referred to the prosecutor for collection.

Regarding Insurance

We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by this surgeon's office. However, you will be personally responsible for your account balance regardless whether or not if your insurance will pay for your total balance of your claims, unless you're eligible for discounts under our indigency policy pre-determined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract. In the event we do not accept assignment of benefits we require that you be pre-approved on our extended payment plan by providing a credit card or personal checking account with authorization to charge that amount for the balance due, if your insurance company/employee benefits plan has not paid your account in full within 45 days or has determined your claims to be your responsibility for the reasons of annual deductible, co-payment, non-covered services and not medically necessary.

If a patient chooses or is required to bill his/her own insurance, this office will provide an itemized statement and a HCFA-1500 Form to the patient, but will treat the account as self-pay.

Regarding Discount

We may offer discounts, reduction or waiver of deductibles, coinsurance and co-pay to any eligible patients based on medical needs and ability to pay on a case-by-case basis under our Corporate Indigency Policy in accordance with applicable federal and state laws. You may apply for

financial indigency discount assistance by asking our staff to determine if you are eligible.

Regarding Surgeon and Facility Charges

We will disclose to every patient our surgeon charges as clearly as practically possible before your medical or surgical procedures if it is known to us. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities.

As you may be aware, your insurance company requires your doctors and surgeons to charge and bill the services separately from surgical facilities or hospitals. You shall not be surprised that you will receive separate surgeon, anesthesiologist and surgical facility bills for your surgery in a surgical facility. If you have any questions about your surgical facility bills, please direct your questions to that surgical center.

Financial Responsibilities

The cost of your procedure may involve several charges for the services provided. The total may include fees charged by your surgeon, the cost of surgical supplies, anesthesia, laboratory tests, and possible outpatient hospital charges, depending on where the procedure is performed. Depending on whether the cost of procedure is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered. The fees charged for this procedure do not include any potential future costs for additional procedures that you elect to have or require in order to revise, optimize, or complete your outcome. Additional costs may occur should complications develop from the procedure. Secondary procedures or hospital day-surgery charges involved with revision surgery will also be your responsibility. In signing the consent for this surgery/procedure, you acknowledge that you have been informed about its risk and consequences and accept responsibility for the clinical decisions that were made along with the financial costs of all future treatments.

___ I understand that if I proceed with cosmetic surgery, I am responsible for the surgical fees quoted to me, as well as additional fees for anesthesia, facility (OR), and possibly laboratory, X-ray, and pathology fees. Surgicenters, Outpatient Centers and Hospitals often have rules that certain tissue /implants removed during surgery must be sent for evaluation that may result in additional fees. Please check with your surgeon for approximate additional costs you will be responsible for.

___ I understand that fees for the consultation and any procedures I may choose to perform are non-refundable once services have been rendered and will not pursue a charge back.

___ I understand and unconditionally and irrevocably accept the financial responsibilities as outlined above.

___ I hereby waive my privacy protection under HIPAA in matters of dispute of payments.

Regarding PPO and HMO Network Participation

As you may know, you may have a choice to choose a surgeon or surgical facilities with or without PPO or HMO participation under different insurance coverage and benefit levels. We are dedicated to providing highest quality care to every patient; however we have no power to change your insurance coverage or network limitations. Most health care plans or insurance policies may provide surgical coverage to non PPO providers and facilities, but at lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you as to our participation status to your insurance plan. We also provide every patient with financial assistance or discount with high deductibles and coinsurance for our Corporate Indigency Policy in accordance with applicable federal and state laws.

At this time, we don't participate in any managed care networks. Most health plans or Insurance Policies may have coverage for out-of-network providers or facilities, but at different or lower percentage or level of reimbursement rates.

We will verify your insurance coverage and obtain pre-certification if applicable for all services as a courtesy to you before your surgery. Please understand that insurance verification is not a guarantee of your payment.

Your Responsibility for Cooperation

If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

In an event that you do receive insurance payment checks for your surgeries rendered by this doctor, you agree to submit such insurance reimburse checks to our office within five (5) days after the receipt of insurance checks. In a failure or refusal to forward or send us the insurance reimbursements checks for the medical services from this provider, all of your discount arrangement will be voided, and the total balance is due immediately, as there is no justification for you to keep the insurance payment for our services as you promised to pay for our services. You further agree to compensate us for any legal fees if we to retain any legal services to collect past dues.

We are committed to serving you with the highest quality care possible at affordable cost. Every staff member at our office is ready to help you at any time.

If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your co-operation.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient/Responsible Party

Date

Signature of Co-Responsible Party

Date