Financial Arrangements and Medical Insurance Consent

We are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your cooperation, and your understanding of our payment policy. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

We will be happy to help you process your insurance claim. You must realize that:
1) Your insurance is a contract between you and the insurance company. We are not party to that Contract.
2) NOT ALL services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3) Our fees are based on the quality of the service provided and generally fall within the acceptable ranges by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, or 80%) of U.C.R. Your insurance company defines U.C.R. as usual, customary and reasonable fees for this region. Accordingly, most companies consider our fees usual, customary and reasonable. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.
We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We expect you to pay for services that your insurance carrier will not cover. We do expect to be paid any balance exceeding 45 days of said professional service. We realize that temporary financial issues may affect timely payment of your account. If such problems do arise, please contact us promptly for assistance in the management of your account. Regular good faith payments towards your balance may prevent collection efforts.

PATIENT PAYMENT RESPONSIBILITY
I have read the FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE form and I understand that all charges incurred are my responsibility whether my insurance company pays or does not. I understand that I am responsible to meet my insurance deductible in addition to payment for any services or treatment not covered by my insurance carrier, as well as to meet all required copayments as defined in my policy.
This practice has offered to file the necessary insurance forms with my primary carrier at no charge, for my convenience. I hereby agree that I will pay promptly any amount outstanding on my account after insurance payments are collected. If the physician is out-of-network with my insurance company, and I receive the insurance payment from the insurance company directly, I will immediately (no later than 5 days after receipt) remand (pay) such monies to the office for services rendered. I understand that failure to complete payment, I may be subject to collection efforts, litigation, and, if I refuse to remand insurance payments, criminal prosecution for insurance fraud.
In the event that my insurance carrier refuses at any time, for any reason, to make payments for my claim for services rendered, I accept responsibility for prompt payment for any treatments and services I have received.
If, for any reason, an account balance is outstanding for six months, my account will be sent to collections. Once the account has been turned over to collections, I understand my account will be listed with credit reporting agencies. Although no emergent medical need will be ignored, I understand and acknowledge that no follow-up visits, procedures, or treatments will be made until my account is paid in full. All returned checks are subject to an additional cancellation fee.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENTS

I have reviewed a copy of the offices Notice of Privacy Practices. (If you desire a printed copy of the notice, please notify the receptionist.)

Assignment of Insurance Benefits and Statement of Insurance

I hereby assign and authorize payment to be made, directly to this medical practice, of all covered insurance benefits including major medical benefits, otherwise payable to me. I also authorize the release of medical information as may be required to process the claims for payment of the medical services rendered and it is expressly understood that the right of such information to be privileged is hereby waived.

There is a non-refundable $500 scheduling fee for a surgical cosmetic procedure.

By my signature, I hereby acknowledge receipt and understanding of this form.

_____ _____

Witness Signature Patient/Agent/Guardian Signature

_____

Date