

Patient's Please Take Notice: We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or billing department.

Please initial each space and sign below:

Authorization for Payment

____ I hereby assign all insurance benefits directly to the Aesthetic Surgery Centre for the payment of my services. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

Treatment Agreement

____ I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

____ For the purpose of payment or authorization, I allow *Aesthetic Surgery Centre*' to release my Private Health Information (including photographs) to any and all of my insurance carriers, their third party payers and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practice to release my information or contact any and all of my treating physicians.

Acknowledgement of Receipt of Notice of Privacy Practices

____ I acknowledge that I was provided a copy of the HIPPA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Financial Policy

UPDATE PERSONAL INFORMATION:

You must inform the office of all personal (home address, phone numbers, etc) and/or insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied by your insurance plan.

COVERED BENEFITS/REFERRALS & AUTHORIZATIONS:

Not all services are a "covered" benefit in all insurance policies; some plans include a waiting period before covering services. In the event your health plan determines a service to be "not covered/pre-existing," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. **Patients are encouraged to contact their plans for clarification of benefits prior to obtaining any services.**

PATIENT BALANCES DUE AT TIME OF SERVICE:

Your portion of payment (co-pays & account balances) for office services is due **at the time of service**. We accept VISA, MasterCard, cash or check.

INSURANCE POLICY:

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you with an assignment of benefits. You are agreeing to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for a minor, will be responsible for payment of services. You are encouraged to contact your designated patient account representative with any questions. **If you are seeing our doctors on an 'Out of Network' basis, you will be subject to out of network rates.**

PAYMENT ARRANGEMENT:

We require all accounts be paid with-in 30 days of insurance payment. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Any payment exceptions will be agreed upon after review of your account. PAST DUE accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

RETURN CHECK FEE:

There is a service fee of \$35.00 for all returned checks. Upon an NSF or CLOSED ACCOUNT occurrence, all future remittances will need to be in other forms of payment. Restitution of "Theft-by-Check" will be requested from the District Attorney's Office.

Patient's Name: _____ Signature of Patient/Guardian: _____ Date: _____

Office Witness: _____ Date: _____ Patient initials to indicate copy received _____