**Financial Policy**

We would like to thank you for choosing Elite Plastic & Reconstructive Surgery as you medical provider. Because we are committed to providing you with the best possible care and service, we would like to make you aware of our financial policy. We require that you read and sign this document prior to receiving medical treatment.

**Co-payments, Deductibles, and Fees:**  Your insurance carrier requires that we collect your co-pay at the time of service. Deductibles and fees for services not covered by your insurance are also due at the time service is rendered. We accept cash, VISA and MasterCard.

**Insurance:** You must present a current insurance card at each visit. If you or your children do not present a current insurance card, you will be responsible for payment in full at the time of service. Your medical insurance is a contract between you and your insurance company. We will assist in filing your insurance claim, but you are primarily responsible for any charges incurred while you are a patient. If your insurance carrier is not one that we participate with, you are responsible for payment in full at the time of service. You have a responsibility to provide timely information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 60 days, because of information that you have not provided, the balance will be transferred to your account and you will be responsible for payment. If the claim is paid at a later date, you will be reimbursed by Elite Plastic & Reconstructive Surgery.

 **Minors and Dependents:** Our practice will bill the insurance for both parents (if applicable). The parent that accompanies the child to his or her first appointment will be considered financially responsible for payment, regardless of the subscriber (parent) listed on the child’s insurance card. We do not get involved in child custody issues.

**Auto Insurance/Third Party Liability:** We DO NOT accept auto insurance or other third party liability insurance. If you are being seen for an injury due to an automobile accident or third party liability, you will be responsible for paying in full at the time of service.

**Missed Appointments:**  We will charge a $25.00 “no show” fee if you fail to keep a scheduled appointment or fail to cancel an

appointment with at least 24 hours notice. This fee is not covered by your insurance plan and is your responsibility. Repeatedly missing, rescheduling, or cancelling appointments may be grounds for dismissal from our practice.

**Prompt Payment:** Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. If you do not have medical insurance, have a financial hardship, or if you are unable to pay your bill in its entirety please contact our office prior to your appointment to discuss payment options with the manager. If you have a past due balance on your account, you may be required to reschedule your appointment. Chronic non-payment will be grounds for dismissal from the practice. We reserve the right to turn any account over to a collection agency if the account is not paid within 30 days.

**Other Fees:** FMLA Forms $35.00; Disability Forms $25.00; Insurance forms $25.00; Letters or other Forms requested regarding a patient $25.00. All fees are charged per request. The fees are due at the time of request. All forms will be ready in3 to 5 working days. No forms will be completed at the time of service. Should you request a copy of your medical records the fee is as follows: the first 25 pages cost $25 and each page thereafter is 15 cents. All medical records require a release form and once the request has been received with payment the office has up to 15 days to complete the request. If you request the records be mailed to you there will be an additional shipping and handling fee which is based on the method of shipping and time required to prepare your documents.

**Patient Financial Responsibility:**

I acknowledge full financial responsibility for services rendered by Elite Plastic & Reconstructive Surgery. I understand that I am financially responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and co-pays. I understand payment of co-pays and any prior balance I may owe is due at the time of service unless a payment agreement is on file. I hereby request that payment of Insurance or Medicare benefits be made on my behalf to Elite Plastic& Reconstructive Surgery for any medical services or supplies furnished to me by that organization.

Print Patent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Legal Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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