Financial Policy

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply financial responsibility on your part.

Insurance: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each vist. If you are insured by a plan we participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. It is the patient's responsibilty to inform the doctor's office if there is a change in health insurance information.

Medicare: We are a participating Medicare provider. As a participating Medicare provider, we will submit your claim to Medicare, as well as your secondary insurance if provided. However; that does not mean that all services are covered. A separate Medicare waiver will be obtained. Covered benefits are subject to Medicare's annual deductible and coinsurance, which is usually 20% of the allowed amount. You are responsible for these amounts due after processing.

Secondary Insurance: Your medical claim will be forwarded to your secondary insurance (if provided) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

Copayments, Coinsurance and Deductibles: All copayments, coinsurance and deductibles must be paid at the time of service. This is required by our contract with your insurance plan.

Self Pay: Payment in full is due at the time of service if you do not have health insurance. Cosmetic payments are payable 2 weeks prior to your procedure.

Non-Covered Services: Please be aware that some of the services you receive may not be covered by insurance. We make our best efforts to obtain authorization from insurance prior to providing services, however there is no guarantee of payment made by your plan. You are responsible for payment of these services.

Referrals/Authorizations: When applicable, we are required to follow the guidelines of your managed care plan which may require a referral from your primary care physician prior to seeking speciality care. You are financially responsible for the services received, unless your referral is presented at the time of this visit. Payment in full is expected upon completion of your visit. If a referral is presented to our office within 48 hours of this visit, credit will be given. You will also be given the option to reschedule your appointment.

Claim Submission: We will submit your claims and assist you in any way we resonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibilty to comply with their request. Please be aware that the balance of your claim is your responsibilty whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Patient Billing: You will be sent up to four notices for amounts deemed to be your responsibilty. After the fourth and last notice, your account may be forced to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, check or credit card. An additional $30.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company issues payment directly to you, thoses funds, along with the explanation of benefits, must be sent to our office to reduce your financial responsibilty.

I have read the above policy regarding my financial responsibilty to **Williams Plastic Surgery Specialists** for medical services provided. I agree to pay **Williams Plastic Surgery Specialists** any balance unpaid by my insurance carrier for myself or the below named person.

Assignment of Benefits: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directlty to **Williams Plastic Surgery Specialists** all insurance benefits, payable for services rendered. I understand that I am responsible for payment of deductibles, coinsurance, copayments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of the signature on all insurance submissions.

Patient Name (please print)	Parent of Authorized Representative (if applicable)
Signature	Date