

Statement of Financial Responsibility

As a courtesy to our patients, our office will bill private insurance for office and surgery procedures.

Every 4 weeks, a statement will be sent out with a message that explains the status of your account. Once your insurance pays, the next statement will request that you pay any remaining balance.

Since the financial responsibility always resides with the patient, we want to keep you informed. For example, if 30 days have gone by and your insurance has not paid, you may wish to call them directly to make sure your account is paid in a timely manner. After 120 days, we will no longer pursue your insurance company, but will look to you, the patient, for payment.

PLEASE READ CAREFULLY: YOUR INSURANCE COMPANY MIGHT NOT FULLY REIMBURSE YOU FOR HOSPITAL ADMISSIONS OR SURGICAL PROCEDURES!

I, _____, hereby give authorization to Seasons Plastic & Reconstructive Surgery to bill my medical insurance company for the services rendered today and in the future, when appropriate. In addition, I hereby give authorization of insurance benefits to be made directly Seasons Plastic & Reconstructive Surgery for services rendered.

I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I understand that it is my responsibility to fulfill any preadmission, referral or second opinion requirements contained in my insurance policy. I realize that failure to do so may result in a significant reduction in my insurance benefits.

In the event that the services rendered are denied coverage per my insurance, I agree to pay all cost of services directly to Seasons Plastic & Reconstructive Surgery. In the event of default, I agree to pay all cost of collection, and reasonable attorney's fees. I hereby assign Seasons Plastic & Reconstructive Surgery all money to which I am entitled for medical and/or surgical expenses relative to the service rendered by Dr. Michelle Spring in the event of a settlement.

I hereby authorize Seasons Plastic & Reconstructive Surgery to release all information necessary to secure the payment of benefits, including photos as necessary. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Name: _____

Patient (or patient's guardian) Signature: _____

Date: _____