

FOX VALLEY PLASTIC SURGERY, S.C.
FINANCIAL POLICY

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Thank you for choosing us as your health provider. We are committed to your successful treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment. If at any time you have questions regarding any treatment, fee, or service, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding.

ALLOWABLE FORMS OF PAYMENT

The patient or his/her legal representative is ultimately responsible for all charges incurred. Our office accepts payment by cash, check and for your convenience, Visa and MasterCard. We also offer patient financing through a couple different companies.

REGARDING INSURANCE

As a courtesy to you, we will bill your insurance carrier for you. Please be aware some and perhaps all of the services provided may be “non-covered” services and are not considered reasonable and necessary under some medical insurance policies. If you are unable to pay in full, it is your responsibility to contact our billing department to set up an agreeable payment plan. Your insurance policy is a contract between you and your insurance company. Our office accepts assignment of benefits from many insurance companies, HMO & PPO programs. However we are not participating providers with all of them. Therefore please inquire as to whether we are with your plan.

INJURIES/ACCIDENTS

If your injury or accident involves litigation, a letter of protection needs to be obtained from the attorney involved.

MEDICARE

We do take Medicare assignment and we will bill Medicare and your secondary insurance for you.

CO-PAYS/DEDUCTIBLES

Payment is expected at time of office visit for co-payments and/or deductibles that is requested by your insurance policy.

BILLING

Statements are mailed monthly and expected to be paid in full within 60 days after your insurance has paid unless other arrangements have been made with the billing manager. If payment is not received in 90 days – it will be turned over to collection.

Thank you for understanding our Financial Policy. If you should have questions or problems, please let us know and we will be happy to assist you in every way possible.

I have read the Financial Policy (above). I understand and agree to this.

Patients or Responsible Party Signature

Date

I consent to having before and after photographs taken of me or parts of my body. These will be used for office and insurance prior authorizations purposes only.

Patients or Responsible Party Signature

Date

I hereby authorize my insurance benefits to be paid directly to Fox Valley Plastic Surgery realizing I am responsible to pay any and all charges that exceed or that is not covered by insurance. I authorize the release of pertinent medical information to insurance and workers compensation carriers.

Patients or Responsible Party Signature

Date