

**The Georgia Institute For Plastic Surgery and  
The Plastic Surgery Center Land, LLC**

*Payment Policy / Assignment of Benefits / General Disclosures*

**Patient Information Label**

**I hereby authorize and assign payment of my insurance benefits to be paid directly to The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC., any medical or surgical benefits that the professional corporation may be entitled to under my medical-surgical plan. I understand I am financially responsible for non-covered services and for any balance due for services excess of the benefits provided by my policy. I authorize the release of any medical or other information necessary to process insurance claims on my behalf. I further permit a copy of this authorization to be used in place of the original. This authorization is to apply to all private insurance claims and Medicare benefits I may use.**

**Financial Liability:** All services rendered by the physicians in this office are on a fee for service basis. Deductible and co-insurance obligations associated with your chosen plan are your responsibility. These will be collected at the time of service for office visits. For cosmetic surgery or other scheduled procedures, these will be collected at least two weeks prior to the procedure/surgery. I understand that I will be responsible for any charges if any of the following apply:

- My health plan requires prior referral by a Primary Care Physician (PCP) before receiving services at The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC. And I have not obtained such a referral, or I receive services in excess of the referral, and/or
- My health plan determines that the services I receive at The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC. are not medically necessary and/or not covered by my Insurance plan, and/or
- My health plan coverage has lapsed or expired at the time I receive services at The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC., and/or
- I have chosen not to use my health plan coverage, and/or
- The physician I see does not participate with my health care plan.
- If for any reason my account should become delinquent, I or my responsible party agrees to pay for all rebilling charges, collection costs, and reasonable legal fees.

**Ancillary Services**

- I understand I may need certain ancillary medical services while I am a patient at The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC.; such as pathology specimen examination, cytology, imaging services, lab work, and cardiac tests. I understand that these services are not provided by any physician of this practice and that I may incur additional charges as a result of the ancillary services. I understand that these services will be billed to me directly or may require payment from me at the time of service. In addition, I may receive in-patient or out-patient hospital care at an area hospital. If so, I will receive a hospital bill for those services. Hospital bills are separate from our doctor services. I am responsible for providing the name of the preferred hospital, laboratory or any other preferred facility/physician in network with my insurance plan.

**Release and Authorization of Information**

- I authorize release of information to my primary care physician and/or referring physician
- I authorize release of information to my employer if this is a work-related condition.
- I understand photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize the taking of photographs at the direction of my surgeon and under such conditions as may be approved by him/her. I understand these photographs will be used solely for documentation purposes and will be kept confidential.
- I have read the Patient Financial Policy and I agree to abide by all terms. A copy of this policy is available on our website, in our lobby, or you may request a hard copy from the front desk.
- **Medicare Signature On File (*Medicare Patients Only*):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me for any services furnished to me by these providers. I authorize the holder of my medical and other information to release to Medicare and it's agents any information needed to determine these benefits or benefits for related services.
- **Tricare Assignment Of Benefits (*Tricare Patients Only*):** I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

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Signature of Patient or Representative

Date / Time

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Signature of Patient of Witness

Date / Time

# The Georgia Institute For Plastic Surgery and The Plastic Surgery Center Land, LLC

## Office Financial Policy

We would like to share the following policies with you so that you understand your responsibility regarding the charges for services rendered to you by these offices. Our doctors and staff are committed to providing our patients with the best possible care. In order to achieve this, we need your assistance and understanding of our medical policy.

### Self Pay Accounts

Self-pay patients are required to pay \$150 at the time of check in and with EACH visit that follows. You are responsible for payment of the balance of your bill should the charges exceed the \$150 you pay at each visit. We designate accounts as self-pay under the following circumstances:

- Patient is covered by an insurance with which our physicians do not participate.
- Patient does not have a valid insurance referral on file, such as HMO or Tricare Prime.
- Patient does not have any health insurance coverage.

### Cosmetic Accounts

Cosmetic patients are required to pay a \$60 consultation fee at the time of check-in. Although you visiting us for something not related to insurance we still require the same information be provided as insurable patients. We have found it necessary to require this information in the event that you need to be seen in our practice at any point for something non-cosmetic. All cosmetic surgical fees are due in full 2 weeks prior to the planned surgical date. Checks are not accepted after this cut off date. All anesthesia and overnight nursing fees are non refundable if you cancel or reschedule within 2 business days of your scheduled surgery.

### Payment Due at the Time of Service

- We accept cash, checks, debit and all credit cards. Returned checks are subject to a fee of \$35.
- Copayments must be paid on the date service is received. A \$10.00 billing fee may be charged to your account if the co-pay is not paid on the applicable date of service.
- You will be responsible at the time of service for the annual deductibles, co-payments, co-insurance, and charges for non-covered or cosmetic services.
- If your co-pay is a percentage and you do not have secondary insurance, a minimum payment of \$35 may be required at the time of the appointment.
- Patient balances are due at the time of check-in, unless payment agreements have been arranged.
- In the event surgery is needed pre-payment is required before the surgery can be performed. You understand that you may be given a quote of cost prior to procedures. You further understand that this quote is just an estimate of charges and not a contract. You understand that during the course of any procedure surgical plans may change and that you will be responsible for any additional charges beyond the quoted charges that are assigned to you by your insurance company based on the contract that is in effect at the time of services rendered.
- Any account not paid in full within 90 days will be referred to our collection management company. In the event your account is turned over to a collection agency, a charge equal to 25% of the outstanding balance will be added to your account to cover the additional collection cost and fees. We reserve the right to terminate you as a patient of this practice if your account gets turned over to collections.

### Proof of Insurance

- It is the policy of our office to follow all federal and state laws and reporting requirements regarding identify theft. As of September 1, 2009, The FTC applied its new "Red Flags Rule" regulations to physician practices. According to FTC Rule, physician practices that accept insurance must have adequate written polices and procedures in place to protect against identity theft. **As a patient, you will be asked to provide a valid photo identification card, insurance card, and a photograph may be taken for our records. You must bring your insurance card and photo identification to every appointment. We will request to see these at EVERY visit. If you do not have a VALID PHOTO ID you will not be seen and will be rescheduled.**
- It is your responsibility to inform the scheduling and registration staff when your appointment may be the responsibility of a third party (auto, liability, or worker's compensation insurance) instead of the patient's health insurance.
- It is your responsibility to notify the practice of changes to your health insurance, address, phone and employment.

### Divorce & Custody

- In cases of divorce, the individual who receives care is responsible for payment of co-pays, co-insurance, deductible and non-participating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.
- The parent who brings the child to the office for care is assumed responsible for payment at the time of service no matter if the account is self-pay, participating or non-participating insurance. The practice does not honor divorce specifics.

# The Georgia Institute For Plastic Surgery and The Plastic Surgery Center Land, LLC

## Office Financial Policy

### Referrals

- If your insurance requires a referral to a specialist, you are required to obtain the referral from your primary care physician PRIOR to your appointment. If you do not have a current, valid referral, we may ask you to either reschedule your appointment or pay for the visit at the time of service. If you are unsure if you need a referral, call the member services number on the back of your insurance card.
- IT IS YOUR RESPONSIBILITY TO VERIFY NETWORK PARTICIPATION OF YOUR PHYSICIAN WITH YOUR INSURANCE CARRIER. As a courtesy we will bill your insurance carrier. However, if we are not a participating/contracted provider with your carrier, you will be billed for services rendered.

### Billing Practices

- We are a Medicare participating provider. We will bill Medicare. You will be responsible at the time of service for the annual deductibles, co-payments, and charges for non-covered or cosmetic services.
- If you have Medicare as well as secondary coverage with a commercial plan, we will bill the carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.
- If you have a commercial insurance plan under which you are covered, we will bill the carrier for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans. It is your responsibility to make sure that we are an "in-network" provider.
- Completion of disability or cancer policy forms will have a fee of \$25 for each occurrence.
- Copying of medical records for personal use will incur an additional fee as allowed by law.

### Cancellation Policy

As a courtesy to our physicians and patients we request a 24 hour (1 business day) cancellation notice for most office visits. Any procedure and/or surgery require 48 hours (2 business days) or more cancellation notice. Please note that weekends and holidays are not considered business days. All anesthesia and overnight nursing fees are non refundable if you cancel or reschedule within 2 business days of your scheduled surgery. If you miss your appointment, or do not cancel with the required notice, additional fees may apply. You may be required to prepay before being rescheduled.

- Office Visit First Occurrence: \$25
- Office Visit Second Occurrence: \$50
- New Patient Visit: \$75
- Procedure/Surgery: Per Dept. Policy

### Auto Accidents/Other Accidents

When your injuries are the result of an accident and an attorney will be handling your case in court or another party's insurance company is presumed responsible for your charges, the patient is still responsible for payment of the bill. The Georgia Institute For Plastic Surgery and The Plastic Surgery Center Land, LLC cannot be expected to wait for the conclusion of long-term court cases or settlement of a disputed insurance claim before being paid. **You will be required to make a payment of \$350 before being seen and with EACH visit that follows. You also are responsible for payment of the balance of your bill should charges exceed the \$350 you pay at each visit.**

### Worker's Compensation

Patients who are injured on the job should report the injury directly to their employer. The employer will be responsible for directing the employee to a doctor who is listed on the PANEL OF PHYSICIANS. Before we will be able to see you as a patient, we will require you to fax or bring in a letter verifying that your employer will be responsible for your charges. If a patient comes in for a visit with out this information, we will have to reschedule the appointment or you will have to pay \$350 to be seen. This information is necessary to avoid the patient being responsible for the bill.