SOUTHEASTERN PLASTIC SURGERY
FINANCIAL PAYMENT POLICY

REGARDING INSURANCE: Our office participates with Medicare and many managed care insurance companies. Should your insurance coverage be with one or more of these companies, we will bill your insurance company along the guidelines of our contract. However, co-payments, co-insurances, and deductibles that have not been satisfied, are the responsibility of the patient and payment is expected at the time services are rendered. If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered and your insurance company will reimburse to you any amount due. As a courtesy to our patients, we will submit a claim to your insurance company.

By signing this form, you authorize the release of any information requested by insurance companies or liable third parties and assign any insurance benefits to Southeastern Plastic Surgery (Benson Timmons, MD and Eric Emerson, MD). If the correct insurance information is not given to Southeastern Plastic Surgery or the proper referral is not obtained, then the patient will be responsible for the bill. You also authorize Southeastern Plastic Surgery (Benson Timmons, MD and Eric Emerson, MD) to release to any other provider, his/her office, or any other medical facility, any information necessary for referral purposes. These authorizations shall remain in force until written notice is given from the patient or responsible person.

SPECIAL NEEDS: There are times when making payment can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise our Accounts Manager as soon as possible.

COLLECTION POLICY: Any unpaid balance due will be forwarded to a collection agency.

Informing our patients about our financial policy assists us in providing the best service to our patients. Thank you for taking the time to read this policy statement. Should you have further questions or comments, please contact our Accounts Manager.

WE ARE HERE TO HELP!

I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay any attorney's fee, court cost, and related collection fees incurred. I also agree my employer may be contacted to verify employment status. In addition I understand that I am financially responsible for all charges whether or not paid by my insurance company for all services rendered on my behalf.

Patient Signature:____

Parent/Guardian Signature:____

Printed Name: ____

Date:______________