

FINANCIAL POLICY

Please review the following Financial Policy, sign, date and give to the receptionist for placement in your chart. We hope the following will answer any questions you may have about our insurance and billing procedures and policies in relation to your appointment.

1. We accept VISA, Master Card, Discover, American Express, cash, money orders, and checks.
2. We must have a copy of your current insurance card in order to file for you or your family member. If you do not have your insurance card, we will ask for payment in full at the time of the visit.
3. If your insurance requires a referral or pre-authorization, we must have this in our office **prior** to your appointment. If we do not have this, we will ask you to reschedule your appointment to such time when the authorization or referral is in our office.
4. We will file any insurance with which we participate; however, we will ask you to pay for any non-covered, co-pay, co-insurance, or deductible amounts at the time of your visit/procedure. For patients with insurance other than who we contract with, we will ask for payment in full on the day of your consultation, and we will give you an itemized receipt to file with your insurance company, or if scheduling surgery we will ask you to pay for any non-covered, co-pay, co-insurance, or deductible amounts.
5. **We do not file with your insurance any charges relative to Pathology services.** All tissue studies and lab tests are sent to either Wake Medical or Greensboro Pathology for processing. If your insurance plan has an exclusive contract with another laboratory provider, you may be subject to out-of-network benefits, or non-coverage of the service. Please verify your coverage with your insurance benefits department.
6. Your Insurance Policy is a contract between you and your insurance company. We cannot guarantee to you that your insurance will pay all or any part of your claim. It is important that you completely understand the provisions of your Policy. It is your responsibility to verify with your insurance company, prior to treatment, your policy, coverages, benefits, and any deductible/co-insurance responsibilities. If your insurance company denies payment of your claim, you should contact your insurance company directly. If your insurance company denies, or only pays a portion of your claim, please understand that you are personally and fully responsible for your total outstanding claim. If they have not paid by the 60th day, you will be held entirely responsible for any balance due, and you will be billed accordingly. Dissatisfaction with your insurance company does not constitute reason to withhold payment of your account with us.
7. It is not our policy to issue refunds unless your account has a credit balance and all claims have been paid. Refunds will not be issued for amounts less than \$10.00.
8. A \$35.00 service charge will be applied to your account for all returned checks or any stopped payment on an issued check.
9. Payment of services rendered to any dependent children rests with the parent who seeks treatment.
10. Please remember that any charges you were provided when you scheduled surgery were ESTIMATES only. Due to the complexity of some treatments, we have no way of stating exactly what the charges will be prior to a surgical procedure.
11. MISSED APPOINTMENTS/CANCELLATIONS - Our policy is to charge for missed appointments or appointments canceled with less than 24 hours notice at a rate of \$35.00. A \$100.00 fee will be charged for any surgery missed or canceled with less than 24 hours notice.

AUTHORIZATION

I agree to be responsible for any medical expenses incurred with Lambeth Plastic Surgery & Aesthetics, P.A. therefore, I authorize my insurance company, attorney, or other parties to pay directly to Lambeth Plastic Surgery & Aesthetics, P.A. and/or provide any information regarding payment of my bill. I have read, understood, and agreed to the financial policy stated above and I accept responsibility for any balance not covered by my insurance company.

Signature

Date