MADISON PLASTIC SURGERY, P.C.

Plastic & Reconstructive Surgery

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Madison Plastic Surgery Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1 Payment is due at the time of service unless arrangements have been made in advance by your carrier, or with our office. We accept Visa and MasterCard.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. If our office has made any special agreements with you, as a courtesy to you, we will file your insurance claim if you assign the benefits to the doctor - in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will I refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a copayment at the time of your visit.

4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service, unless special arrangements have been made with our office.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will I be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient (or responsible party, if minor) Date

Please print the name of the patient