# FINANCIAL ARRANGEMENTS AND INSURANCE

We are dedicated to providing you with the best possible care. If you have medical insurance, we are committed to helping you receive your maximum allowable benefits. In order to receive these goals, we need your assistance and your understanding of our payment policy.

For cosmetic surgery, we will provide you with all the costs involved including the surgical fee, the operating room fee, and the anesthesia fee, as well as any other fees that are applicable. Payment for surgery is due two weeks prior to surgery date and includes a 90 day post-operative period following the date of surgery. CareCredit is an available rescource for payment options.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. However, your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

A claim will be sent to your insurance company the week following your surgery. On a more complicated surgery, reports and medical records will usually be requested by your insurance company. In sending these reports promptly, we hope to maximize your payment. Our staff is efficient and knowledgeable about insurance matters and would be happy to answer your questions at any time.

Our practice is committed to providing the best possible treatment for our patients, and we charge what is reasonable and customary for our area. This does not apply to companies who reimburse based on arbitrary fee schedule, which bears no relationship in full regardless of any insurance company's arbitrary determination of usual and customary rates.

We believe it is important that our patients fully understand our financial policy before any surgery so that we may better serve you and avoid any problems post-operatively. Please feel free to call the office if you have any questions regarding any of our policies.

I have read the above Financial Agreement and understand/agree to this Financial Policy.

____________________________________ ____________________

Signature of Patient/Responsible Party Date

*(A)*Notifier(s):

*(B)* Patient Name: *(C)* Identification Number:

# ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

***NOTE:*** If Your Insurance doesn't pay for *(D)*_____________ below, you may have to pay.

Your Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the *(D)*____________ below.

| *(D)* | *(E)* Reason Your Insurance May Not Pay: | *(F)* Estimated Cost: |
|---|---|---|
| ________________ | | |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the *(D)*____________listed above.
  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your Insurance cannot require us to do this.

| *(G)* OPTIONS: Check only one box. We cannot choose a box for you. |
|---|
| ☐ **OPTION 1.** I want the *(D)*__________ listed above. I may ask to be paid now, but I also want my Insurance billed for an official decision on payment, which is sent to me on an Explanation of Benefits. I understand that if my Insurance doesn't pay, I am responsible for payment, but **I can appeal to my Insurance** by following the directions for my plan. If my Insurance does pay, you will refund any payments I made to you, less co-pays or deductibles. |
| ☐ **OPTION 2.** I want the *(D)*__________ listed above, but do not bill my Insurance. I may ask to be paid now as I am responsible for payment. **I cannot appeal if my Insurance is not billed.** |
| ☐ **OPTION 3.** I don't want the *(D)*__________listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my Insurance would pay.** |

*(H)* **Additional Information:**

**This notice gives our opinion, not an official Insurance decision.** If you have other questions, please contact your insurance carrier. Signing below means that you have received and understand this notice. You also receive a copy.

| *(I)* Signature: | *(J)* Date: |
|---|---|
| | |

***(A)*Notifier(s):**

***(B)* Patient Name:** ***(C)* Identification Number:**

# ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

***NOTE:*** If Medicare doesn't pay for ***(D)***____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the ***(D)***____________ below.

| *(D)* | ***(E)* Reason Medicare May Not Pay:** | ***(F)* Estimated Cost:** |
|---|---|---|
| | | |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the ***(D)***____________listed above.

  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

***(G)* OPTIONS:** **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the ***(D)***__________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the ***(D)***__________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the ***(D)***__________listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

***(H)* Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

| ***(I)* Signature:** | ***(J)* Date:** |
|---|---|
| | |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.