

OFFICE POLICIES and PATIENT AGREEMENT OF FINANCIAL RESPONSIBILITY

1. As the patient, it is your responsibility to check and see if your insurance is in-network with Lakeview Plastic Surgery.
2. If you have HMO insurance, you are responsible for your referrals. Referrals are only valid for 90 days from the issue date, and are only good for as many visits as your primary doctor has approved.
3. You are responsible for knowing the policies of your insurance, such as co-payments, co-insurance, deductible, pre-existing conditions, policy exclusions, effective date, termination date, etc.
4. Co-pays and self-pay procedures are due at the time of service, without exception.
5. If you need to cancel and/or reschedule an appointment, please notify the office 24 hours in advance. If you can less than 24 hours in advance, or no show for your appointment, you will be charged a \$30 fee.
6. If you are going to be late for your appointment, please call. It will be at the discretion of the physician if you will be seen if you arrive more than 15 minutes late.

Acknowledgment of Financial Responsibility

I, _____, acknowledge and understand that my bill for services I have requested and received will be sent to the insurance I have provided. Any unpaid portion including **deductible, co-pay, co-insurance, or rejected claim is my full financial responsibility.** It is my understanding that I will pay the entire balance in full once the insurance has settled the account.

I understand the office policies as outlined above.

Patient Signature

Date

Patient Name