

# **ALLEGANY PLASTIC SURGERY FINANCIAL POLICY**

**SELF PAY** – Full payment is due at the time of service. We accept cash, checks, Visa, Mastercard and Discover. CareCredit is also accepted; however, all applications and correspondence is strictly between the patient and CareCredit. Our office may not contact CareCredit on your behalf.

**MANAGED CARE INSURANCES:** Your insurance requires a referral from your Primary Care Physician in order for your visit to be covered. If you do not have a referral at the time of appointment, you may reschedule to a later date to give you time to obtain this from your physician. If you choose to be seen without a referral we will ask that you pay for the visit at the time of service, since it will not be covered by your insurance.

**MEDICAID:** You must supply the office with your numbers for verification. If you have an MCO insurance it is necessary for you to have an authorization or referral for your visit to be covered (this can be obtained from your primary care physician).

**WORKERS' COMPENSATION:** Any patient being treated for a work-related injury needs to supply the office with the employer's name, address, and insurance carrier for billing purposes. If you do not supply this information we will have to list you as a self pay patient and payment will be required at the time of service.

**LITIGATION:** If you have a claim against someone else for causing the injuries for which you are treated, you are responsible for payment of your bills even though you may be entitled to recover that cost from the other party.

**PHOTOGRAPHY:** I authorize Allegany Plastic Surgery and/or assistants to use photography, as it is necessary for insurance approval and medical teachings.

**RELEASE OF INFORMATION:** I authorize the release of any medical information necessary to be released to the insurance company or insurance carrier that may be necessary to process my claim for payment. I also authorize assignment of payment to Allegany Plastic Surgery.

**I HEREBY VERIFY THAT ALL THE INFORMATION GIVEN IS CORRECT.**

**I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR ARE NOT COVERED BY INSURANCE.**

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Signature \_\_\_\_\_ Date \_\_\_\_\_

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Witness \_\_\_\_\_ Date \_\_\_\_\_