FINANCIAL POLICY
THE CENTER FOR COSMETIC AND LASER SURGERY

Fees:
We request that all charges be paid in full at the time service is rendered. If your insurance company reimburses you directly for services billed, you are responsible for payment of all balance(s) due. If our office receives an NSF check from you, you will be charged $25.00. We will no longer be able to accept a check from you. We will accept cash, money order, or credit card for future services. We accept VISA, MASTERCARD, OR DISCOVER.

Participating Provider Insurance Plans:
We will collect all applicable co-payments as designated by your plan at the time of service. Your claim will be submitted to your insurance company, and you will be balance billed for any amount remaining unpaid by your insurance for which you are responsible. We agree to accept your insurance plan's schedule of Maximum Allowances for covered services, or, if less, billed charges.

Worker's Compensation:
We will submit **confirmed** worker's compensation claims for our patients. If you were injured at work, there is no guarantee your bill will be covered under worker's compensation.

Motor Vehicle Accidents/Personal Injury Insurance:
Our patients are expected to pay at time service is rendered. If you were injured in a motor vehicle accident or sustained a personal injury where another party could be held liable, you are responsible to obtain the necessary information.

UCR Statement:
If any portions of our fees are not covered by your insurance company, we want our patients to be aware of the fact they are responsible for any balance due after the insurance payment. This balance due includes provisions set by your insurance company such as: co-insurance, deductible, and "usual and customary" or " reasonable and customary" allowances. The policy held by you or your employer is a contract between the policyholder and the insurance company. We do not accept your insurance company as our patient. YOU are our patient.
If you are not familiar with your insurance coverage, we ask that you discuss your policy with your employer or insurance company prior to charges being incurred.

Predetermination / Precertification:
Please inform our office if your insurance company will require a Predetermination for surgery, a SECOND OPINION, or has a preferred facility. If a predetermination letter is required, please provide the insurance company's name, address, phone, claim, group, identification/policy numbers, and the contact person to whom we should address the letter.

Fee for Copies of Protected Health Information:
If you request a copy of your Protected Health Information, we will charge a fee for costs incurred to comply with your request. Illinois law prohibits charges that exceed the following: $20.00 handling fee plus $.75 per page for pages 1 –25; $.50 per page for pages 26 – 50; and $.25 per page for pages 51 or more. Requests for copies of Protected Health Information must be in writing and addressed to the attention of the Privacy Officer.

Fee for Accounting For Disclosures of Protected Health Information:
Patients may request an accounting of disclosures made only on or after April 14, 2003. You may request one accounting of disclosures within a 12 month period free of charge. For each additional request within the same 12 month period, a fee of $20.00 will be charged. A request for an accounting for disclosures must be in writing and addressed to the Privacy Officer.

Fee For Completion of Disability Forms:
Initial form will be completed free of charge.
Fee for completion of subsequent FMLA packets is $15.00. Other subsequent or Disability Forms are $10.00. Fees are due in advance of forms being completed.

RELEASE / ASSIGNMENT

I hereby authorize the release to my insurance company or its representative any information, including diagnosis and/or records of any treatment or examination rendered to me during the course of such medical care. I also hereby assign all medical benefits including major medical benefits to which I am entitled from government sponsored programs, private insurance, and/or any other health plan to: Jeffrey S. Poulter, M.D., F.A.C.S. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be as valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance. I also agree to pay any additional charges related to the cost of collection, (including, but not limited to, collection agency's fees, attorney's fees, court fees, certified letter fees, and handling fees) in the event that I would fail to pay my bills on a timely basis. I hereby authorize said assignee to release all information necessary to secure payment.

I acknowledge that I have read and understand the Financial Policy of Jeffrey S. Poulter, M.D., F.A.C.S.

Signature of Patient/Responsible Party **Date**

Relationship

(Revised July 2004)