

## Financial Responsibility for Services

Dear Patient,

Syracuse Plastic Surgery will submit a request to your insurance company carrier for financial reimbursement for services provided to you.

In the event that your insurance carrier denies payment and any co-insurance you have does not cover these services your signature below confirms that you agree to be personally and fully responsible for all costs associated with the services provided to you.

Thank You

### 1. FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Syracuse Plastic Surgery. I am responsible for any applicable deductible or co-payments prior to the provision of services. For surgery and treatment, Syracuse Plastic Surgery will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment or procedure, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgement payment.

Syracuse Plastic Surgery may file a claim for payment with my insurance company as required by contractual agreement. If the insurance company fails to pay Syracuse Plastic Surgery in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Syracuse Plastic Surgery. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including reasonable attorney's fee.

### 2. RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is my responsibility to provide Syracuse Plastic Surgery with a copy of my current insurance card and to obtain a referral from my Primary Care Physician (if required by my insurance). Syracuse Plastic Surgery is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. I will notify Syracuse Plastic Surgery immediately upon any change in my insurance.

### 3. INSURANCE WAIVER AND NON-COVERED SERVICES WAIVER

I understand that if I do not have a copy of the current insurance card and valid referral, if required, Syracuse Plastic Surgery is not obligated to see me, but will if I still wish to be seen, I can be seen as a "Private Pay" patient. I agree that neither Syracuse Plastic Surgery nor I will file a claim for the visit. I will be required to pay the total cost of the visit in advance.

In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan ("Non-Covered" Services); I understand I must pay for "Non-Covered" Services. If feasible, a waiver will be completed for each "Private Pay" visit or "Non-Covered" Service.