KEVITCH
CHUNG & JAN
AESTHETIC SURGERY ASSOCIATES

PLASTIC SURGERY & DERMATOLOGY

PATIENT FINANCIAL POLICY

Thank you for choosing **Aesthetic Surgery Associates**. We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

Payments for all services will be due at the time services are rendered. We accept cash, check, Visa, MasterCard, American Express and Discover. Returned checks and unpaid balances may be subject to collection placement and collection fees.

Self-Pay/Uninsured: Payment in full is required for all self-pay/uninsured patients. Please refer to the ASA Fee Payment Policy for our surgical payment policy.

Insurance: The patient is expected to present an insurance card at each visit. Billing of insurance is a courtesy we provide our patients and is not required by law. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. If any payment is made directly to you for services billed by Aesthetic Surgery Associates, you recognize an obligation to remit payment to Aesthetic Surgery Associates.

Co-payments and Deductibles: Your insurance contract **REQUIRES** that we collect your designated co-pay at the time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please be prepared to pay your co-pay prior to each visit, or you will be required to reschedule. If you have questions regarding any amount due after insurance has processed your claim, please contact your insurance carrier directly.

Referrals: If your insurance plan requires a referral, it is your responsibility to obtain this prior to your appointment and have it with you at the time of the appointment. If you do not have your referral, you will be required to reschedule.

Non-covered services: If your insurance plan determines that a service is not covered for any reason, you will be responsible for payment of the charges.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Workers Compensation/Other Accident Cases: For Aesthetic Surgery Associates to file a claim with your workers' compensation or other liability carrier, you must provide complete billing information (including claim number). Patients shall be financially responsible for medical services related to workers' compensation/accident if insurance fails to pay in full.

Missed appointments: Our policy is to charge for missed appointments not cancelled within a reasonable amount of time. If you need to cancel or reschedule your appointment, we ask that you provide adequate cancellation notice: at least 48 hours in advance for plastic surgery and dermatology appointments, and aestheticians.

Aesthetic Surgery Associates reserves the right to retain the consult deposit fee for appointments not cancelled within the requested timeframe when a consult deposit is taken.

A scheduling fee of $50 for insurance related appointments, and $100 for cosmetic related appointments is required to reschedule a missed appointment, or an appointment cancelled without adequate cancellation notice.

Disability/FMLA forms: The completion of disability and/or FMLA forms is not reimbursable by insurance carriers; therefore, fees are your payment responsibility. Payment is expected upon presentation of forms for completion. Please allow 7-10 business days for completion of these forms.

I HEREBY AUTHORIZE AESTHETIC SURGERY ASSOCIATES TO RELEASE TO MY INSURANCE CARRIER ANY NECESSARY INFORMATION TO FILE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO AESTHETIC SURGERY ASSOCIATES. I UNDERSTAND I AM RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Printed Name of Patient **Date**

_____

Signature of Patient or Responsible Party

_____

Relationship if Other than Patient

PATIENT CONSENT FOR USE OF CREDIT/DEBIT CARDS & FINANCING
DISCLOSURE OF PROTECTED HEALTH INFORMATION

Services that are performed that are paid for with a credit card, debit card or financial third-party are not eligible for payment challenges and services are protected. By signing this form, I am irrevocably consenting to allow Aesthetic Surgery Associates to use and disclose my protected health information to any Credit Card Entity, Bank or Financing Company **only** when they request such information to process an account and assist with payments such as Health Savings or Flexible Spending Account.

I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise. This non-credit card challenge agreement is irrevocable.

Please note that you may refuse to sign this form. If you do refuse, we cannot accept any form of payment by Credit or Debit cards including Flexible Spending or Health Savings Account.

_____ _____

Signature of Patient or Legal Guardian **Date**

☐ I refuse the Credit/Debit Card Agreement for Aesthetic Surgery Associates. I understand I will only be able to pay by cash or check.