RESPONSIBILITY STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay the co-pay, deductible, co-insurance and any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible but you are responsible for your bill.

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

The Non-Medicare Patient

I authorize the release of all medical information necessary to process this claim that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Plastic Surgical Associates and its' physicians. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to, co-payments, co-insurance, deductibles and non-covered services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

The Medicare Patient

I request that payment of authorized Medicare benefits be made to me or, on my behalf, to Plastic Surgical Associates for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until evoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

If applicable, I request payment of authorized MEDIGAP benefits to be released to Plastic Surgical Associates.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT COMPLETELY.

Patient Signature: ________________________________ **Date:** ______________