# *Burt and Will Plastic Surgery and Laser Centre*
# *Financial Policy*

Thank you for choosing **Burt and Will Plastic Surgery and Laser Centre** as your health care provider. Please understand that payment of your bill is considered a part of your treatment. Your clear understanding of our financial policy is important to our professional relationship.

All Patients must complete our "Patient Registration and Medical form" prior to seeing the doctor.

- Co-pays are due at the time of service.
- There will be a $35.00 service charge on all returned checks.
- The charges made for your visit depend on the nature and the complexity of your problem. If you have any questions regarding the charges made for any visit, please feel free to contact our billing office.
- Any charge that becomes sixty (60) days old without satisfactory payment provision having been made will be considered delinquent and charged a $15.00 statement fee for each statement sent out . We reserve the right to turn over delinquent accounts to a debt collection agency or an attorney for collection. Costs associated with the collection efforts will be added to the balance due to Burt and Will Plastic Surgery and Laser Centre.
- We accept cash, checks, Visa, MasterCard, Discover and Care Credit.

**Cosmetic Consultation Fee**

- A $50.00 cosmetic consultation fee is due at the time of the initial consult.
- This fee covers the initial consult with either Dr. Burt or Dr. Will.
- If you see both Dr. Burt & Dr. Will, the fee is $50.00 for each Physician.
- This applies to consults for cosmetic procedures only.

**Cosmetic Surgery Policy**

- A scheduling fee of $200.00 is due at the time of the preoperative appointment or time of surgery scheduling.
- This fee is non-refundable and will be deducted from the surgery fee.
- The surgery fee is due in full two weeks prior to the date of surgery.
- A cancellation less than two weeks prior to the date of surgery will result in 50% cancellation fee.
- Cancellation the day of surgery will result in a 100% cancellation fee.

**BWPS is not responsible for errors in billing made by third party vendors such as Chase Credit, Care Credit, Visa, MasterCard, and Discove**r.

**Medicare** - I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information) Regulations pertaining to Medicare assignment of benefits also apply.

**Illinois Health Partners** HMO - A referral from your primary care physician is required at the time of your appointment.

**Covered Services** - Some health plans do not cover all services. If we are aware that your plan excludes certain services you will need to pay for those services at the time they are rendered.

**If you do not currently have medical insurance a fee of $250.00 will be required at the initial physician visit**.

I understand the above listed financial policy and agree to abide by this agreement.

Signature _____ Date _____

**Release of Information and Authorization for Assignment of Benefits**

I authorize the physician and staff to do any medical treatment, test or care deemed necessary. I authorize Burt and Will Plastic Surgery and Laser Centre to release to my insurance company or its representatives, information including the diagnosis and the records of any treatment or examination rendered to me that they may require processing my claim for benefits. I authorize and request that my insurance company pay directly to the above named practice the amount due me in my pending claim for medical treatment of services, by reason of such treatment or services rendered to me. This assignment will remain in effect until revoked by me in writing. I understand and agree that, (regardless of my insurance policy, I am responsible for the entire balance on my account, for all professional services provided to the patient (or myself). I have read all the information contained in the financial policy. I certify that, to the best of my knowledge, this information completed is correct and true. I will notify this office in case of any changes to my health or any of the attached information.

Signature _____ Date _____