West Maple Plastic Surgery

FINANCIAL POLICY

West Maple Plastic Surgery believes that communicating our financial policy is good healthcare practice. Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and us. We will file with your primary and secondary insurances. Secondary insurances typically pay according to a coordination of benefits with the primary insurance.

You are responsible for all copays, coinsurances, deductibles and non-covered services. We accept cash, debit card, checks (at least 2 weeks prior to surgeries), Visa, MasterCard, Discover and American Express. Statements are sent out monthly, and we ask that balances due be paid when you receive your statement or at your next appointment, whichever is sooner. There is a $20 returned check service charge. Payment will then need to be made by cash, money order or credit card for the balance due.

When you receive healthcare services from Dr. Sherbert and we bill your insurance, it is the same as though we are extending you credit. You receive the service and we await payment from you and/or your insurance. Due to the high cost of rendering care and the lowering reimbursements by many insurers, we simply cannot carry large balances. Balances not paid within 90 days will be turned over to an outside collection agency, unless prior payment arrangements have been made.

Some patients may accrue large balances for services provided. We will work with these patients to set up a mutually feasible payment plan. **Please understand that we cannot waive deductibles, coinsurances or copays that are required by your insurance. This is a violation of our contracts with the insurance plans.**

I, _____, understand and agree to West Maple Plastic Surgery's Financial Policy. I understand that if my insurance company denies my claim for any reason, I will be responsible for payment to Dr. Sherbert. I also acknowledge that I am responsible for all copays, coinsurances, deductibles and non-covered service charges resulting from my treatment by Dr. Sherbert.

Signature: _____Date _____

Witness: _____

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