

THOMAS R. VECCHIONE MD

FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your insurance carrier. We accept cash, checks and Visa, MasterCard. ***Credit cards are not accepted for payment of cosmetic surgery.***
2. It is your responsibility to provide current and updated insurance information and an appropriate insurance card that is patient specific.
3. Your insurance policy is a contract between YOU and your insurance COMPANY. As a courtesy to you, we will file your insurance claim. ***If your insurance plan does not pay the practice within a reasonable period of less than 45 days, we will hold you responsible and bill you directly.*** If we receive a check from your insurance carrier, we will refund any overpayment to you.
4. If your insurance plan is one we are contracted with we will bill them and you are required to pay any co-payment, co-insurance or deductible at the time of service.
5. Should your insurance require referrals and or pre authorization, it is your responsibility to obtain the referral and to verify that prior authorization is in place.
6. **For all non-contracted plans you will be responsible for payment at the time of service.** We will submit the claim, however, the payment will be mailed directly to you.
7. Not all insurance plans cover all services. In the event that your insurance plan determines a service to be “non covered or cosmetic”, you will be responsible for the complete charge. See attached waiver. Payment is due upon receipt of a statement from our office.
8. Untimely surgical cancellation (within 48 hrs) **will** result with a financial penalty.
9. Surgical revisions when necessary, done within one year of the original surgical date **may not** incur a surgeon’s fee – however, - ***there will be additional charges for facility and anesthesia.*** This is true for procedures billed to your insurance company as well as cosmetic surgery done here at our surgical suite.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient (or responsible party, if minor)

Date

Print name of the Patient