

Faerber Surgical Arts

FINANCIAL POLICY

Thank you for contacting our office. We appreciate the confidence you place in us by choosing our practice for your health care needs. We will uphold that responsibility by providing you the service you desire and deserve. We will strive to make your time spent with us as comfortable and as pleasant as possible. For your convenience, we accept the following forms of payment:

- **Cash or Check**
- **Visa, Mastercard and Discover**

PRIVATE PAY PROCEDURES (Oral and Medical Surgeries other non-insurance covered procedures)

A \$500.00 deposit is required at the time you schedule surgery. This deposit is non-refundable if you cancel your procedure. **Payment in full is required ten (10) days prior to surgery.** If you cancel your surgery within 48 hours of your scheduled procedure, your payment will not be refunded. However, you will have a credit balance for that amount (less the deposit) that can be applied towards future surgery.

INSURANCE REIMBURSABLE PROCEDURES

If you are having surgery at Faerber Surgical Arts for a procedure covered by your insurance carrier; we will review your fee with your insurance company prior to surgery to determine their coverage and the amount you will be responsible for if we are a participating member of that carrier. **Your portion of the fee is due on the day of your surgery.**

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. **THE AMOUNT PAID BY YOUR INSURANCE CARRIER IS NOT PAYMENT IN FULL.** Our fee for each service has been determined through careful analysis. These fees are reasonable and reflect other area physicians' charges. You are responsible for your payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS

The adult and/or the parent/guardian accompanying a minor is responsible for payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, Mastercard, Discover or payment by cash or check at the time of service.

LABORATORY/PATHOLOGY

Some services require specimens to be sent to an outside diagnostic laboratory. Costs for these services are NOT included in our fee. You will be billed separately by an outside lab.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THE FINANCIAL

POLICY. If I have insurance, this signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the physician named of the insurance benefits otherwise payable to me.

Signed: _____

Date: _____