Patient Billing and Financial Agreement
Chart #___________

Welcome to Gallaher Plastic and Reconstructive Surgery. We are dedicated to providing you with high quality care and service. We regard your understanding of our financial policies as an essential element of your care. Your signature below indicates that you have read, understand, and agree to the following terms, which explain Gallaher Plastic and Reconstructive Surgery's billing and financial policies:

1. **Insurance Coverage.** I understand that I am ultimately financially responsible for my own bill and for possessing a clear understanding of my insurance policy, if any. I understand that if I am using insurance, I have a responsibility to provide Gallaher Plastic and Reconstructive Surgery with complete and accurate information about my insurance. It is my responsibility, not the responsibility of Gallaher Plastic and Reconstructive Surgery, to understand the terms of my insurance coverage. This includes but is not limited to a knowledge of which services are covered; where services can be performed; whether my provider is in-network; whether my employer has any specific guidelines regarding network providers; the amounts of any deductibles, co-payments, or co-insurance; and an understanding of which referrals, if any, are required. By signing this document, I understand that I remain primarily liable for payment of all medical services provided by Gallaher Plastic and Reconstructive Surgery not covered by my insurance. I further understand that Gallaher Plastic and Reconstructive Surgery cannot guarantee payment from my insurance company. I understand that just because my physician or the employees of Gallaher Plastic Surgery may believe insurance should cover a service does not mean that my insurance will actually do so. I understand and agree that such opinions or beliefs of my physician or the employees of Gallaher Plastic and Reconstructive Surgery are not a guarantee that my insurance will pay for my care.

2. **Policies for Specific Services.**

   a. **Initial Consultation.** Payment for the initial consultation (or co-pay for insurance patients) must be made in full at the time of service. I understand that if my initial consultation (or co-pay) is not paid in full at the time of service, future non-emergent appointments will not be scheduled for me until such time as I pay the outstanding balance.

   b. **Cosmetic Surgeries and Procedures.** Cosmetic surgeries and procedures are not usually a benefit covered by insurance companies. I understand that if my procedure is not covered by insurance, I will be responsible for pre-paying for my surgery or procedure on the day of the first pre-surgical visit.

   c. **Medically Necessary Surgeries and Procedures.** I understand that any surgery or procedure deemed by a physician to be "medically necessary" will be billed directly to my insurance company. I understand that I am responsible for paying for any portion of the charges for such surgery or procedure which is not paid by my insurance company.

d. **Post-Operative Services.** I understand that standard post-operative visits are considered part of my surgery or procedure. I understand that I do not incur additional costs unless the post-operative course of care includes complications or a protracted amount of time from the date of surgery. If my post-operative care is considered a billable service, I further understand that it will be billed directly to my insurance company. I understand that I am responsible for paying for any portion of the charges for such post-operative care which is not paid by my insurance company.

3. **Appeals.** If my surgery, procedure or visit is submitted to insurance, I understand that it may be necessary for me to appeal my claim if my insurance company either does not pay or if its payment does not cover the entire amount. Gallaher Plastic and Reconstructive Surgery will provide me with operative notes, office visit notes, and other materials in my chart; but I understand that any necessary appeals are entirely my responsibility. I further understand that it is up to me to initiate any appeal with my insurance company and to find out what needs to be done to initiate and follow through with that process.

4. **Prior Authorizations and Referrals.** I understand that it is my responsibility to determine whether a prior-authorization or referral is required for my surgery or procedure.

5. **Past Due Amounts and Debt Collection Practices.** In the event my account accrues an unpaid balance, I understand that I will be given a grace-period of sixty (60) days. After the expiration of sixty (60) days, I understand that I will be charged annual interest in the amount of 10%. I further understand that my account may be referred to a collections agency if I accrue an unpaid balance and no payment is made toward that balance for a period of ninety (90) days. I understand that if I have an unpaid balance in excess of $100, I must pay that balance in full before Gallaher Plastic and Reconstructive Surgery will provide further non-emergent services to me.

6. **Payment Plans.** Gallaher Plastic and Reconstructive Surgery will negotiate payment plans on a case-by-case basis. I understand that all such payment plans must be arranged and approved by Gallaher Plastic and Reconstructive Surgery and the terms of such plans will be set out in a separate, written contract between Gallaher Plastic and Reconstructive Surgery and me.

7. **Cancellation / No-Show Policy.** I understand that if I need to miss an appointment, I am required to call and cancel. I further understand that if I do not call and cancel my appointment at least two (2) business days in advance, I will be charged a $50 late-cancellation / no-show fee. I agree to be responsible for paying this fee should it apply; and I understand that it will not be covered by my insurance company.

8. **Rescheduling or Cancelling Surgeries or Procedures.** I understand that cancelling or rescheduling my visit, surgery or procedure could require Gallaher Plastic and Reconstructive Surgery to incur administrative costs and to expend employee time. I also understand that this could adversely affect other patients. Accordingly, I understand that Gallaher Plastic and Reconstructive Surgery will reschedule a surgery or procedure for me once, at no charge, so long as I request the same no later than three (3) weeks prior to the scheduled surgery or procedure. If: (a) I wait to reschedule within three (3) weeks prior to the scheduled surgery or procedure, or (b) I request that my surgery or procedure be rescheduled a second time, I understand that I will be responsible for paying a one-time rescheduling fee of $200. I further understand that this fee will not be covered by my insurance company.

9. **Showing up Late.** I understand that if I am delayed for a scheduled appointment, other patients may be adversely affected. I further understand that Gallaher Plastic and Reconstructive Surgery will take reasonable steps to see me on the day of my appointment. If I arrive more than fifteen (15) minutes late, however, I agree that Gallaher Plastic and Reconstructive surgery may reschedule my appointment at its sole discretion.

10. No-Show Policy for Surgeries / Procedures

In the event I fail to appear for a scheduled surgery or procedure, I understand that I may be charged the full amount for my surgery or procedure and will not be entitled to a refund of any prepaid services.

By signing this document, I agree that I have read, understand, and voluntarily agree to be bound by its terms.

______________________	______________________	___/___/_____
Print Patient Name	**Signature Patient/Guardian**	**Date**