DIBELLO
PLASTIC SURGERY

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OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Your Insurance
We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. We participate with several insurance carriers. We will bill those carriers with whom we are participating. Not all services are covered benefits of all contracts. Some insurance companies arbitrarily select certain services that they will not cover. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. Also, should your insurance company for any reason not reimburse us directly or if we should not hear form this company in reference to a claim, you will be responsible for full payment. **Please be sure to provide our office with the most current and correct insurance information. You must also notify our staff of any insurance changes prior to being seen by Dr. DiBello.** Lack of the correct insurance information or **failure to pay your insurance premium(s)** may cause your claim to be rejected for payment, **in which case you will be responsible for the entire amount**. The following policies will apply:

- **Co-payments are due at time of service.**
- **You will be notified of the estimated cost of the procedure as determined by your specific insurance plan for the service/procedure scheduled.**
- **All unmet deductibles and co-insurance that apply must be paid at the time of any office procedure or prior to any procedure performed at the hospital/surgery center.**
- **For all nonparticipating health plans, the surgical fee is required to be paid prior to the procedure.**
- **Any collections/outstanding balances have to be satisfied in order to proceed with surgery.**

Referrals and Preauthorizations
You are responsible for obtaining any referral and/or preauthorization that your insurance company requires. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

Cosmetic Services
All cosmetic consultations are payable at the time of service, and all fees collected for the consultation are non-refundable. If you elect to undergo a cosmetic procedure, the consultation fee will be credited towards Dr. DiBello's surgical fee if surgery is performed within six (6) months. All non-surgical cosmetic procedure fees are payable at the time of service. All cosmetic surgical procedure fees are payable in full two weeks prior to the time of service unless other arrangements have been made.

Credit Card Payments
We do accept credit card payments (Visa/MasterCard), however, there will be a **3% non-refundable administrative fee assessed for all credit card transactions.**

Minor Patients
For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements.

 Patient Signature _____ **(continued on the next page)**

FINANCIAL POLICY CONT'D

Outstanding Balance Policy

It is our office policy that all past due accounts be sent a statement which is due upon receipt. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made or we do not hear from you, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes, but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Returned Checks

The charge for a returned check is $50.00, payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check. For same day services we will accept personal checks, however, we will need a valid credit card authorization on file in the event the check is returned. When a check is returned, the credit card on file will then be charged for the amount of the services provided plus the returned check fee.

Miscellaneous

Disability Forms: There will be a $30.00 service charge for **each** disability form, leave of absence, and any other form you request Dr. DiBello to complete.

Missed Appointments: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess a $30.00 missed appointment fee.

Record Copying: Fees for the retrieval, copying, mailing, etc. of records are in accordance with the fees set forth and adjusted annually by the PA Department of Health (41 Pa.B. 6453)

ASSIGNMENT AND AUTHORIZATION TO RELEASE:

I request that payment of authorized benefits be made either to me or on my behalf to Joseph N. DiBello, Jr., M.D. for any services furnished to me by that provider of service. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related service(s).

I have read and understand the financial policy of the practice and I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account.
I agree to be bound by its terms.

_____

Please Print the Name of the Patient

_____ _____

Signature of Patient Date/Time

Responsible Party If Patient is a Minor:

_____ _____

Please Print the Name of Responsible Party Relationship to Patient

_____ _____

Signature of Responsible Party Date/Time