Surgical Arts of Virginia
R. Shane Palmer, M.D.

Financial Policy & Consent

Our office strives to provide our patients with the best possible care and service. We try to schedule our patient's appointments in such a way to make your visit as convenient and pleasant as possible. We have the following policies in place so that you understand your obligations. If you have any questions, please do not hesitate to speak with an administrative staff member.

Scheduling of Services: All cosmetic surgical procedures require a $500.00 **non-refundable** deposit to reserve appointment time.

Payment for Services: We require payment of one-half the entire fee not less than 2 weeks prior to scheduled date of surgery. This payment is non-refundable if patient cancels procedure within 7 days of reserved surgery date. The balance must be paid on or before the surgery date. We accept Visa, MasterCard, Discover, CareCredit, Cash, Check. There is a surcharge when using a credit card. We have made prior arrangements with most insurance providers. We will bill such providers as a courtesy to you and require a co-pay (if any) at the time of service. We require any remaining balance not covered by your insurance to be paid by you prior to service being rendered. Similarly, if you need to undergo any procedures not covered by insurance, you will be responsible for payment of all charges prior to service being rendered. For all services rendered to minors, the parent or legal guardian will be responsible.

Prescriptions: It is the patient's responsibility to request all prescription refills during your scheduled appointment. Any prescription lost or not requested at the time of your visit will be subject to a $15.00 pharmacy fee.

Clerical Forms: For single-page forms that our office is required to fill out there will be a $10.00 charge. Any extensive forms (such as disability or FMLA forms) will incur a $25.00 charge.

Returned Check Fee: I understand and agree that if any payment made by me or on my behalf by check is returned from the financial institution as unpaid, in addition to the original

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sum, I am responsible and agree to pay a $50 returned check fee. A copy of this agreement may be used in place of an original.

Assignment of Benefits: I certify that the insurance information provided about my insurance coverage is correct. I further authorize the release of any information necessary, including medical information for this or any claims generated from this office for covered services provided to my insurance carrier. A copy of this authorization may be used in place of the original. I hereby assign the benefits payable for covered services to be paid directly to Surgical Arts of Virginia.

Medicare Patients: I authorize the holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carriers any information for all Medicare claims. I assign the benefits payable for covered services to Surgical Arts of Virginia. A copy of this authorization may be used in place of an original.

Guarantee of Payment: I understand and agree that I am responsible for payment of all professional services rendered now and in the future by this practice. If I am insured and this practice is a participating provider with my insurance, I am financially responsible for all payments my insurance company identifies as my responsibility. I agree to pay all balances due in a timely manner (within 30 days). A copy of this agreement may be used in place of an original.

Collection Fees: If I do not pay all balances owed by me in a timely manner (within 30 days), the undersigned hereby agrees to pay 18% interest per annum on said balances to accrue from the date professional services were originally rendered; plus, attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus, court costs. If the undersigned fails to pay promptly for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining credit information and/or locating the undersigned as may be necessary.
In the event prompt payment is not made by the undersigned, the undersigned understands that personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's Business Associate in compliance with federal HIPAA regulations. A copy of this agreement may be used in place of an original.

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Signature of Patient or Responsible Party Date

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Print Name Relationship (If Responsible Party)

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