CHARLESTON OCULOFACIAL
PLASTIC SURGERY

Financial Policy

Thank you for choosing Charleston Oculofacial Plastic Surgery. We are committed to providing you with compassionate health care. Please read our financial policy below, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1.Insurance: Our participation with your insurance plan will be verified during your registration for each office visit. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is ultimately your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If your insurance requires a referral from your physician, you must have a letter from your referring physician prior to your office visit to have coverage.

2.Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company and your responsibility to know what your plan will and will not cover. You may be required to pay any deductibles or co-pays you may have with your insurance company prior to any procedure/surgery being performed. Please help us in upholding the law by paying your co-payment at each visit.

3.Insurance payment: Your insurance company requires us to tell you that we will bill your insurance company (accepting assignment) and your insurance company will reimburse Charleston Oculofacial Plastic Surgery.

4. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by insurers. We will notify you of non-covered services before they are rendered. You must pay for these services in full either at the time of the visit, or within a pre-arranged time frame.

5.Self-Pay and Elective Cosmetic: A quote for your surgery/procedure will be provided to you. This quote will be honored for 180 days. A 1000$ deposit will be required at the time of surgery scheduling and this fee will be credited towards your procedure on the agreed to surgery date. This fee becomes non-refundable at 30 days prior to your surgery date. The remainder of the balance is due 2 weeks prior to surgery. This fee is

50% refundable within 7 days of surgery and non-refundable within 3 days of surgery if surgery is cancelled or rescheduled by the patient.

5.Proof of insurance. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6.Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7.Coverage changes. If your insurance changes, you agree to notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

8.Nonpayment. Payment on all accounts billed is expected within 30 days. If payment is not received within 30 days, a monthly administrative fee may be added to offset postage and other office costs generated by multiple billings. If your account is over 120 days past due, you will receive a notification indicating your account is overdue and we may refer your account to a collections agency and you may be discharged from this practice. In addition, delinquent accounts that are referred to a collections agency may incur an additional surcharge. Should this occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9.Missed appointments.

a) Office visits: We understand that unforeseen circumstances may cause you to miss an appointment. In general, we ask for 24 hours advance notice for cancellations/rescheduling, or you will incur a 50$ fee. A credit card must be kept on file in order to make an appointment. After three cancellations or rescheduling with less than 24-hour notice, we reserve the right not to re-book an appointment. Please help us to serve you better by keeping your regularly scheduled appointment.

b) Surgery Rescheduling: If you reschedule a surgery date for a service covered by your insurance within two weeks of surgery date, we charge a $100 rescheduling fee.

10.Requests for medical records. If you need a copy of all or portions of your medical record, please complete a Release of Information Consent form provided to you by the office. Please allow at least 2 weeks for copying. If you need your records copied sooner, please let the front office know and we will do our best to accommodate you. We charge $0.65 for the first 30 pages then $0.50 per page for the remaining pages as well as a $15.00 clerical fee and actual postage and applicable sales tax.

(*Note: Section 44-115-80of the South Carolina Physicians' Patient Records Act states "a physician may charge a fee for the search and duplication of a medical record, but the fee may not exceed $0.65 per page for the first 30 pages and $0.50 per page for all other pages and a clerical fee for searching and handling not to exceed fifteen dollars per request plus actual postage and applicable sales tax." A physician must provide a patient's medical records at no charge when the patient is referred by the primary physician to another physician or healthcare provider for continuation of treatment for a specific condition or conditions."*)

Charleston Oculofacial Plastic Surgery is committed to providing the most compassionate treatment to you and your family. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns! I have read and understand the payment policy and agree to abide by its guidelines Signature of patient or responsible party.

Patient or Legal Guardian:_____

Date:_____