JOSEPH
Advanced Oculofacial Plastic Surgery

# Summary of Financial Policies & Notice of Privacy Practices

## Summary of Fees and Financial Policies

| Fee | Reason | Charge |
|---|---|---|
| Cosmetic Consult | Cost for in person consultation for cosmetic services | $150 |
| Cosmetic Virtual Consult | Cost for virtual consultation for cosmetic services | $120 |
| Cosmetic Surgery Deposit | Deposit to reserve a date for cosmetic surgery. Applied to outstanding balance. Refundable if surgery is cancelled or rescheduled with 7 days' notice. | 20% |
| No Show Appointment | Cancel or reschedule appointment with less than 24 hours' notice | $25 |
| No Show Surgery | Cancel or reschedule surgery less than 7 days before surgery | $100 |
| Returned Check | Bank returns check for any reason | $40 |
| Declined Credit Card | Credit card is declined | $40 |
| Late payment | Bills not paid in full within 30 days of billing date. An additional fee if not paid in full within 60 days of original billing date | $35 |

**By electronically signing this form below, you acknowledge that you understand that the above fees are not covered by any insurance plan, including Medicare and Medicaid, and that it will be your responsibility to pay these fees.** Exceptions to this fee schedule will be at the sole discretion of the management of JOSEPH Advanced Facial Plastic Surgery, PLLC, and will only be made for unusual and extenuating circumstances.

**For Self Pay/Cosmetic/Non-Insurance Patients:**

**Consultation Fees:** The consultation fees are due in full prior to being seen on the day of your visit. This nonrefundable fee can be applied towards the balance of any surgeries or procedures you choose to have performed or scheduled (not applicable for injectables such as Botox or fillers)

**Surgery Deposit for Cosmetic Services:** To confirm your date of surgery, a 20% deposit of the surgery fees is required. This deposit will be applied towards the final amount you owe for your surgery. This deposit is refundable, provided you cancel or reschedule your surgery at least 7 days prior to your surgery.

**For Functional/Reconstructive/Insurance Patients:**

**Your insurance company determines how much you owe**. For insurances with whom we participate, your insurance will be billed on your behalf, and your insurance company will determine the portion you are required to pay, based on your individual insurance policy. If you are concerned about coverage for any of the services, you agree to contact your insurance company prior to your visit or prior to your surgery or procedure(s). **By electronically signing this form below, you certify that you (or your dependent) have insurance coverage as you have provided and agree to have insurance payments made directly to JOSEPH**

**Advanced Oculofacial Plastic Surgery, to be applied to your account for services rendered. You also acknowledge that you are financially responsible for all charges incurred in the event that your insurance denies payment, and you are aware that there may be additional collection and/or attorney's fees if your account is referred for collection.** For patients covered by Medicare Part B without a secondary insurance, the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

**Out of Network Services**: Please note that if our practice is not enrolled in your insurance plan, your visits and surgery will be considered "Out of Network". We will provide you with a good faith estimate of your bill at or shortly within the time of scheduling. All out of network services must be paid in advance and in full for any office visit or surgery. You will then be given a "Super Bill" to submit to your insurance for reimbursement, which might cover all, some, or none of the charges based on their policies. If you are not sure if Dr. Joseph is in your network, please call your insurance company to verify before your appointment.

**Deductibles/Copays: Co-pays, deductibles, and any other outstanding balances or fees are due before being seen on the day of your appointment**. Patients with deductibles will need to either pay the outstanding deductible plus co-pay amount or $200, whichever is less, before being seen. After your insurance is billed, any outstanding balance owed will be billed to you. Any overage will be applied to your account or refunded.

**Assignment and Release**: **By electronically signing this form, you acknowledge and agree to the following:**

1. **Payment will be made directly to JOSEPH Advanced Facial Plastic Surgery, PLLC (DBA JOSEPH Advanced Oculofacial Plastic Surgery) by your insurance company, and you accept financial responsibility for all services not covered by your insurance.**
2. **If your insurance sends payment to you directly, you will forward and endorse that insurance check to JOSEPH Advanced Facial Plastic Surgery, PLLC to cover services rendered. You understand that failure to do so is insurance fraud.**
3. **You authorize release of any medical care information requested by your insurance company required for payment of in your insurance claim.**

**For All Patients:**

**Late fees:** Late fees will be charged if any bills sent to you is not paid in full by the due date. A $35 late fee will be charged on day 31 from the billing date. An additional $35 late fee will be assessed on day 61 from the billing date. If the balance is not paid on or before day 70, we reserve the right to assign your balance and late fees to a collection agency.

**Payment Methods:** We accept cash, check, and all major credit cards.

JOSEPH
Advanced Oculofacial Plastic Surgery

**Minor and Parent or Guardian Responsibility**: You understand that whoever accompanies your child to their appointment has authorization to consent to medical care as needed and is responsible for payment of medical services. You acknowledge your responsibility for payment of all services provided by JOSEPH Advanced Oculofacial Plastic Surgery in accordance with the practice's fees and terms.

## Acknowledgement of Summary of Financial Policies

By electronically signing this form, you agree that you have read the entire Summary of Financial Policies of JOSEPH Advanced Facial Plastic Surgery, PLLC (DBA JOSEPH Advanced Oculofacial Plastic Surgery). You can request a written copy of the financial policy or privacy practices, or you can view a copy at www.JOSEPHface.com. The policies can be updated at any time without written notice. You also acknowledge that you have asked for clarification on any items that were unclear to me before signing.

**Please only sign this document after you have read, understand, and agree to all terms of the policy statement.**

Note: The financially responsible party must sign this form and provide a valid photo ID before the patient can be seen. It is for your protection and to prevent fraud.