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 booking in person consultation for cosmetic services*	$150
Cosmetic Virtual Consult	Cost for booking virtual consultation for cosmetic services*	$120
Cosmetic Surgery Deposit	Deposit to reserve a date for cosmetic surgery**	20%
No Show Functional Appointment	Cancel or reschedule appointments with less than 48 hours notice	$50
No Show Functional Surgery	Cancel or reschedule surgery less than 14 days before surgery	$200
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
Chargeback Fee	If you initiate a credit card chargeback, a minimum of $50 plus any additional fees incurred through the chargeback process will be patient responsibility	Variable

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:

***Cosmetic Consultation Fees:** The consultation fees are due in full prior to being seen on the day of your visit. This non-refundable fee can be applied towards the balance of major surgeries or procedures you choose to have performed or scheduled (not applicable for injectables such as Botox or fillers or minor office-based procedures). If the appointment is cancelled for any reason at any time or in the event of a no-show, this consultation booking fee would not be refundable. If the appointment is rescheduled with >48 hours' notice, the consultation fee can be applied towards the new appointment date provided the appointment occurs within 90 days.

****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.

- In the event of a reschedule request made with >14 day notice, this deposit will apply towards the new surgical date.

- In the event of a reschedule request made with < 14 day notice, a late reschedule fee of $200 will apply. The deposit will apply towards the new surgical date.
- In the event of a cancellation with > 14 day notice, the surgical deposit is refundable less a 5% processing fee which is not refundable.
- In the event of a cancellation with < 14 day notice, this surgical deposit is not refundable.

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). Please note that Explanation of Benefits received by the patients may not indicate the end of all insurance and claim processing. In the event you provide us with inaccurate insurance information, or fail to resolve incorrect coordination of benefits documentation with your insurance companies within 7 days, you will be personally responsible for outstanding charges. **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 coverage/payment, or you fail to provide our office with updated insurance information less than 3 business days before a scheduled clinic appointment or less than 21 days before a scheduled surgical procedure.** Final processing of insurance claims may take more than one year, and may not be finished processing even if you have received an explanation of benefits document.

Failure to Pay: If you fail to pay an outstanding account balance by **30 days after a patient statement**, your account may be referred to a collection agency for non-payment, which could have an adverse impact on your credit. In the event your account is referred for collection, you will be responsible for additional collection and/or attorney's fees.

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 our providers are 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 pay the estimated outstanding deductible plus co-pay and coinsurance amount, before being seen. For patients covered by

Medicare Part B without a secondary insurance, the patient will be responsible for 20% of the estimated Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply. After your insurance is billed, any outstanding balance owed will be billed to you. Any overage will be applied to your account or refunded.

Credit Card on File: Credit Card on File will be obtained from all patients. In the modern era of medicine, many patients have insurance plans that have a high deductible/patient responsibility, but this is not always readily apparent. After your insurance processes the claim, if there is an outstanding balance due to the clinic, we will notify you and provide you with an invoice/statement. If the invoice/statement is not paid within 14 days, unless we receive other instructions, we will charge the credit card on file for the remaining balance.

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 your insurance claim.**
4. **You authorize us to charge your credit card on file for an outstanding account balance.**

For All Patients:

Late fees: Late fees will be charged if any outstanding balance is not paid in full by 30 days after you are notified. A $35 late fee will be charged on day 31 from the date of an outstanding patient balance notice. An additional $35 late fee will be assessed on day 61 from the date of the outstanding patient balance notice.

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

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

JOSEPH
Advanced Oculofacial Plastic Surgery

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.

SMS Text Messaging Policy

By electronically signing this form, you agree that you have read the following statement: For the convenience of our patients, our organization sometimes communicates with our patients by SMS text messages related to services we are providing. Any usual message and data rates may apply, and message frequency varies. In the patient check-in form, you will have the option to consent to or opt out of SMS text messaging. If you decide to opt out, you may notify any of our staff members and we will no longer communicate with you through SMS messages. You may also text us STOP at any time to opt out of receiving SMS text messages from us.

Acknowledgement

By signing below, I agree that I have read the Financial, SMS and Privacy Policies of JOSEPH Advanced Facial Plastic Surgery, PLLC. I can request a written copy of the document, or I can view a copy at www.JOSEPHface.com. The policies can be updated at any time without written notice. I have asked for clarification on any items that were unclear to me before signing.

Name (please print): _____Signature of Responsible Party:_____

Relationship to Patient: ☐ Self ☐ Other: _____