PITTMAN PLASTIC SURGERY, PC
FINANCIAL POLICIES

MEDICARE AND INSURANCE WAIVER

It may become necessary to release your protected health information to insurance companies, financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

I understand that Medicare and/or other Insurance Companies will only pay for services that they determine to be reasonable and medically necessary. Medicare is covered under Section 1862(a)(1) of the Medicare law. If Medicare and/or Insurance Companies determine that a particular service is not "reasonable and medically necessary" under their standards, they will deny payment for that service(s). I have been notified that Medicare and/or other Insurance Companies may deny payment for services rendered. I understand and agree that I am responsible for payment of services rendered.

CREDIT CARDS, DEBIT CARD, AND FINANCING - DISCLOSURE OF PROTECTED HEALTH INFORMATION

Services that are performed and are paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Pittman Plastic Surgery, Plastic Surgery of Athens, PC and/or Dr. C. Edwin Pittman to use and disclose my protected health information to any credit card entity, bank, or financing company when they request such information to process an account and assist with payment.

____ I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

NO SHOW/CANCELATIONS

We are honored you have chosen our office and look forward to taking care of you. We have set aside the amount of time needed for your appointment, in order to provide you with the highest level of care. We understand that there may be times when you are not able to make your scheduled appointment and ask that you kindly give our office a 24-hour notice. If you do not show up for your scheduled appointment, you will be charged a No-Show Fee.

- If you are an established patient and fail to notify our office, there will be a **$150.00 No Show Fee** charged to your account that will need to be paid at the time of rescheduling your appointment.
- If you are a new patient and fail to notify our office, there will be a **$150.00 No Show Fee** charged to the credit card that was obtained when scheduling your appointment.

If you have an unforeseen circumstance that does not allow for a 24-hour notice, please contact our office to speak with our office administrator, who may be able to waive the No Show Fee.
No Show Fees are the patient's responsibility and will not be billed to your insurance company.
I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

FMLA/SHORT TERM DISABILITY PAPERWORK

FMLA/Short Term Disability Forms can be sent via fax, e-mail or hand-delivered. If hand-delivered, all forms must be given to the front desk, not to clinical staff. Each set of forms will incur a $30 processing fee. Once we receive payment for the forms, please allow 5 business days for completion of the forms. **Forms will not be completed on the same day that they are dropped off,** so please plan accordingly. FMLA/Short Term Disability Forms for a family member will also be subject to the $30 processing fee. Any documents or letters will only be completed/written in the immediate pre and post op period only.

_____ _____
Patient Signature Date

_____ _____
Witness Date