San Antonio Plastic Surgery Institute

414 W. Sunset, Suite 215
SAN ANTONIO, TX 78209
210-495-4100

FINANCIAL POLICY

We sincerely thank you for choosing our office for your health care needs. Please understand that payment of your bill is considered part of your treatment. Filing your insurance is a service provided to you free of charge, but in no way relieves you of your responsibility of your bill, (i.e. deductible, usual and customary rates and services not covered by your plan). The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

INSURANCE COVERAGE: Insurance is designed to reduce your costs, but usually will not eliminate them entirely. You are fully responsible for all fees charged by this office regardless of your insurance coverage. We will make every effort to fully inform you of all fees due and your insurance payment status. We try our best to verify your insurance coverage before you receive treatment; however, this is not always the case. This office does not accept total responsibility for verifying your insurance or for collecting your insurance claim. Ultimately the responsibility is the policyholders.

PAYMENT AUTHORIZATION: I request the payment of authorized Medicare, Medicaid, or private insurance benefits to be paid directly to Michael E. Decherd, MD, for any services/procedures provided to me. I understand that I am responsible for non-covered services or any portion not paid by my insurance carrier.

PAYMENT OF BENEFITS: I hereby authorize payment of benefits to Michael E. Decherd, MD for services performed. I understand that I am financially responsible for charges not cover by this assignment.

PATIENT AUTHORIZATION: I authorize the release of any medical information necessary to process this claim. This information will be used for the purpose of evaluating and administering claims for benefits. I agree that a photographic copy of this authorization is as valid as the original.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED BY ME IN THIS OFFICE EXCEPT FOR CHARGES REQUIRED TO BE WRITTEN OFF BY CONTRACTUAL AGREEMENT. I HAVE READ, UNDERSTAND AND AGREE TO THE PROVISIONS OF THIS FINANCIAL POLICY.

Thank you very much. We look forward to serving you.

signature_____

date_____