

SHOLAR CENTER FOR AESTHETIC SURGERY & AGE REJUVENATION, LLC FINANCIAL POLICY AGREEMENT

Thank you for choosing us as your healthcare provider. We are committed to your successful treatment. The following is a statement of our financial policy, which we require that you read and sign prior to treatment. Anytime you have questions regarding any treatment, fee, or service, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding. Please read the following financial policy agreement and sign at the bottom.

METHODS OF PAYMENT

This office will accept the following methods of payment for services rendered:

Visa/Mastercard/Debit Cards/ACH/Cash/Money Order/Cashier's Check/Personal Checks.

We offer **CareCredit** payment plans to help with the cost of your surgical treatment. We offer **in-house payment plans** only for our Age Management and Hormone Replacement Program participants. Please refer to the specific program policy or the surgery financial policy for more detail.

REGARDING INSURANCE

Methods of Filing. Responsible parties with insurance coverage can either:

- o File insurance yourself and pay us in full directly the day services are rendered. We will assist you with your paperwork.

- o Have us file your insurance. We will only file with 2 insurance plans. Filing of any additional plans will be your responsibility. You **must** have on the day of your appointment: Insurance card with Subscriber's information, a Photo ID (We do not file ANY insurance without a photo ID – driver's license), the co-payment and deductible prior to services are rendered.

Verification of Insurance. Insurance coverage will be verified at the time of service. You must provide this office with an insurance card or proof of coverage. If coverage is unable to be verified, you are responsible for all charges incurred.

Necessary Treatment. The most common misconception concerning insurance is that your policy will cover the total cost of surgical fees charged. Insurance is designed to reduce your out of pocket cost, but usually will not eliminate it entirely. Your surgical treatment is not dictated on what your insurance will cover. Together, Dr. Sholar and you create your treatment plan based on what your current medical needs are. We cannot limit your care to just what is covered by your insurance plan. Every plan is different and each insurance company determines what is covered. Just because a particular service is not covered does NOT mean you do not need it. Insurance will not be filed for cosmetic surgery. Likewise, if Dr. Sholar determines that your procedure is not medically necessary, insurance will not be filed.

EOB. We are not privileged to all insurance plans limitations and exclusions. You, as the beneficiary of the insurance policy, are responsible for knowing all policy limitations and exclusions. The contract for benefits is between you and your insurance company. Our only relationship is with you, the patient. We will assist you in understanding your benefits, but are not responsible for your benefits or what is ultimately paid by your insurance plan. Any discrepancies should be addressed with your insurance company as they make the final determination of benefits provided- not us. You are responsible for verifying that all waiting periods have been satisfied prior to surgery. Annual maximums, deductibles, and percentages of coverage may be different on the day of surgery based on care received by other practitioners and the medical necessity of the procedure as determined by your insurance company. Dr. Sholar does not determine medical necessity for your insurance company, but will assist in providing justification for surgery to your insurance company to assist in determination

of benefits. You, as the patient, are ultimately responsible for the full amount of the surgical cost.

Financial Responsibility. Insurance is filed as a courtesy to you and coverage does not relieve you of the financial responsibility, nor suspend payments until the insurance has paid. Ultimately, you are the one responsible for the account. Nevertheless, as a courtesy to you, we will bill your insurance carrier for you. Please be aware some, and perhaps all, of the services provided may be “noncovered” services and are not considered reasonable and necessary under some medical insurance policies. If your insurance carrier fails to pay your claim within 60 days from the date of service, a second notice will be sent to your carrier, however, the balance will become patient responsibility, and it is your responsibility to contact your carrier regarding unpaid claims. If you are unable to pay in full, it is your responsibility to contact our billing department to setup a mutually agreeable payment plan. **Accounts in arrears for 90 days will be submitted for collection, referred to necessary legal authorities and credit bureau, and may result in court action if prior arrangements to pay have not been made or if you fail to make your agreed upon installment payments.** Kindly note that your insurance policy is a contract between you and your insurance company. We are not a party to that contract, and cannot be responsible for their failure to timely pay for services rendered.

CO-PAYS/DEDUCTIBLES

Payment is expected at the time of office visit for co-payments and/or deductibles that are required by your insurance policy.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment possible for patients and we charge what we believe is appropriate, usual and customary for the area. You are responsible for payment in full regardless of any insurance company’s determination of the usual and customary rates for similar procedures and treatment. We do not accept reasonable and customary charge calculations by other outside parties. Any adjustments/write-offs will be applied upon receipts of payment and EOBs.

THIRD PARTY BILLING

We do not file with automobile or home owners insurance liability policies. Services are to be paid in full by you and you can seek reimbursement from the liability insurance company. You are required to make payments on the charges even if they will be covered by a third party.

COMPLETION OF MEDICAL FORMS

A \$10 fee plus actual postage will be charged for completion of all forms by our office. These forms include all FMLA, disability, life insurance, credit, loan claims, cancer, AFLAC, etc.

REQUEST FOR MEDICAL RECORDS

Requests for medical records will be honored in a timely manner as required by applicable law. All requests should be made at least 72 hours in advance of date needed. Additionally, a charge for copying and mailing medical records may be assessed per and only to the extent allowed by applicable laws. Should your attorney request medical records on your behalf, one invoice will be sent to the attorney for payment, however the bill is the responsibility of the patient regardless of who requested the records on the patient’s behalf. Records will not be released without appropriate documentation of authorization of release.

RETURNED CHECK FEE

We also charge a returned check fee. The current charge is \$40 per check. If you are notified by our office that your check was returned and not honored for payment, we will afford you a limited opportunity to replace the returned check with cash or a bank cashier's check in the amount outstanding plus the service fee. To avoid your account being referred to collections or reported to the authorities, you must present to us, at our offices, the replacement cash or bank cashier's check no later than close of business on the next business day immediately following the day you are notified by us of the returned check. Please note that persons who knowingly write bad checks may be prosecuted for fraud in the State of Indiana. Patients acknowledge that they are responsible for any and all collections costs and/ or attorney fees, service fees, and court costs associated with the collection of outstanding balances on their account.

MEDICARE & WORKER'S COMPENSATION

Our office will not accept new Medicare or Worker's Compensation assignments.

COSMETIC SURGERY QUOTE

After you and Dr. Sholar have determined your surgical plan, we will provide you with a quote of your estimated surgical fees. It will include your consultation, pre-operative visit, procedure and any implants required, and post-operative/follow-up visits. You will also be given an estimate of the fees of the hospital/surgery center and anesthesia services. We will collect a deposit of 20% of the surgery quote in order to schedule and hold your desired date of surgery. For more detail, please refer to the Financial Policy specifically regarding Cosmetic Surgery. Full payment for cosmetic surgery is due at our office at your preoperative appointment prior to surgery. The facility and anesthesia fees will be collected from you at the hospital/surgery center prior to surgery. Additional charges for required labwork, pathology fee, and electrocardiogram, or for additional surgery time will be billed separately by the lab or hospital. Additionally, we recommend that you be covered by regular health insurance at the time of your cosmetic surgery in the rare instance you should develop a severe postoperative complication. All charges related to additional procedures for complications are the full responsibility of the patient.

APPOINTMENT LATE CANCELLATION/NO SHOW FEE POLICY

Please provide us with at least 24 hours advance notice for any appointment changes. This will enable us to better accommodate another patient.

In an effort to assure scheduling efficiency, patients who fail to call within 24 hours of the appointment will be billed a cancellation fee. There is a \$50 no show/cancellation fee for office visits/consults. Should you miss or make a late cancellation for procedures or spa services scheduled, you will be billed for 50% of the cost of the procedure. These will not be billed to your insurance company. If you have an emergency, we will evaluate a waiver of these fees on a case-by-case basis. Although we will do our best to do courtesy reminder calls for consultations, procedures, and spa services, it is the patient's responsibility to remember the day and time of their appointment. Payment of the NO-SHOW FEE must be made in cash, valid credit card, or verified check before further appointments are allowed.

SURGERY CANCELLATION/NO SHOW FEE POLICY

We understand that a situation may arise that could force you to reschedule, postpone, or cancel your surgery. Please understand such changes affect not only your surgeon and her staff, but other patients as well. We appreciate the courtesy of notification as early as possible in order to make the time available to other patients. Should you cancel your surgery within the

two weeks prior to the scheduled date, your 20% deposit will be withheld. Should you reschedule within the two weeks prior to the surgery date, a \$150 rescheduling fee will be assessed.

By signing this form below:

-You agree to pay all costs of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency. **(Please Initial_____)**

- I acknowledge that I have read and understand the foregoing Financial Policy;

- I agree to this policy as a condition of receiving services or treatment;

- I hereby authorize my insurance benefits to be paid directly to Sholar Center for Aesthetic Surgery & Age Rejuvenation, LLC;

- I realize I am responsible to pay any and all charges that exceed or that are not covered or paid by insurance;

- I further authorize the release of pertinent medical information to insurance carriers for all purposes necessary and appropriate for the submission and payment of claims for and on behalf of my account with Sholar Center for Aesthetic Surgery & Age Rejuvenation, LLC.

I, (please print)_____ have read and agree to the above financial policies. I understand it is my responsibility to pay any fees to this office.

Signature_____ Date_____

If you have insurance, you must sign below:

I authorize release of any information relating to this claim. I understand that I am financially responsible for all costs of treatment. I hereby authorize payment of the medical and/or dental benefits otherwise payable to me directly to the below named entities.

Alina D Sholar, MD

Sholar Center for Aesthetic Surgery, LLC

Signature_____ Date_____

Thank you for understanding our financial policy. If you should have questions or problems, please let us know and we will be happy to assist you in every way possible.