Statesboro
Plastic Surgery

Assignment of Benefits

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to STATESBORO PLASTIC SURGERY for services rendered to me. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. Coinsurance and deductible are based upon the final determination of the Medicare Carrier and are my responsibility.

2. SUPPLEMENTAL INSURANCE: STATESBORO PLASTIC SURGERY will file my supplemental insurance claim on my behalf. My signature below authorizes release of the information to the insurance company. I request that payment of authorized secondary insurance benefits be made on my behalf to STATESBORO PLASTIC SURGERY. If my supplemental insurance plan pays me directly, I agree to remit said payment immediately to STATESBORO PLASTIC SURGERY.

3. RELEASE OF INFORMATION: STATESBORO PLASTIC SURGERY may disclose all or any part of my medical record and/or financial ledger to any person or corporation which is or may be liable or under contract to STATESBORO PLASTIC SURGERY for reimbursement for services rendered, and to any health care provider for continued patient care. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: STATESBORO PLASTIC SURGERY participates with most major insurance plans and will make a reasonable effort to notify me if STATESBORO PLASTIC SURGERY has no contract, expressed or implied, with my particular insurance plan. Notification may be verbal or by signage. However, it is ultimately my responsibility to understand my insurance plan's coverage, benefits and limitations. I agree to be responsible for all items or services rendered by STATESBORO PLASTIC SURGERY regardless of insurance coverage, and I accept full financial responsibility if incorrect or untimely insurance information is given by me to STATESBORO PLASTIC SURGERY.

5. NON-COVERED SERVICES: I understand that STATESBORO PLASTIC SURGERY contracts with insurance plans relate only to items and services which are covered by the insurance plans, and that STATESBORO PLASTIC SURGERY does not determine what defines a covered benefit of my insurance company and cannot make any guarantees about coverage. That determination is made only by my insurance plan after the claim is received. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health care service plans to be non-covered. Examples of non-covered items may include services considered to be routine, cosmetic, preexisting or experimental, and treatment or tests not recognized by the health care service plan.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by STATESBORO PLASTIC SURGERY, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to ECNC for payment.

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Patient Name (Please Print) Date

_____ _____

Patient Signature / Responsible Party Date