FINANCIAL POLICY

Welcome to our office. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments that you need. Therefore, if you have any questions or concerns about out payment policies, please do not hesitate to as our financial counselor.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information form prior to seeing Dr. Funcik.

Payment for service is due at the time services are rendered. We accept cash, check and for you convenience, MasterCard, Visa, Discover, and Carecredit.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Signature: _____ Date: _____

INSURANCE POLICY (for Cancer patients ONLY)

We will file your insurance for your reimbursement as long as we have all the correct insurance information.
In special instances, we may accept assignment of insurance benefits. We do participate with several plans including Medicare, all Blue Cross Blue Shield Plans, Tricare, and several others. **Please check with the front desk to find out if we participate with your specific insurance.** We will file secondary as well. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 90 days, we ask that you contact the carrier to help speed things up.
5. If your account has been turned over to collections, you agree to pay all legally allowed interest and all collections and attorney fees.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account

INSURANCE ASSIGNMENT

I authorize payment directly to Coastal Facial Plastic, P.A., for the medical and/or surgical services rendered. This is to include health and/or liability, “Medigap” policies, and other insurances, including auto casualty. I authorize any holder of medical information about me to release to the healthcare financing administration and its benefits payable for related services. In the event that my insurance company does not pay for the service(s) rendered, I accept personal responsibility for the expenses incurred and further request that these services be provided.
Signature: _____ Date: _____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Coastal Facial Plastic Surgery, P.A. for any service(s) furnished to me b that office. . I authorize any holder of medical information about me to release to the healthcare financing administration and its benefits payable for related services. If determinations are made by Medicare that specific services are not covered by Medicare Policy, you agree to be responsible for payment of non-covered charges.

Signature: _____ Date: _____