



EAST LAKE  
PLASTIC SURGERY CENTER

Patient Name: \_\_\_\_\_

Account #: \_\_\_\_\_

**DESIGNATED RELATIVE**

\_\_\_\_\_(Initial) I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations) with: *Please list the family members or significant others, if any, whom we may inform about your medical condition.*

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

**PRIVACY NOTICE**

\_\_\_\_\_(Initial) I have received a copy of ISIDOROS MORAITIS, M.D.'s office *privacy notice* as required by HIPAA that provides a complete description of *personal health information* uses and disclosures. I have been provided an opportunity to review it.

**FINANCIAL POLICY**

**USUAL AND CUSTOMARY FEES:** Our practice is committed to providing the best medical care for our patients. We charge what is usual and customary for our area. All patients are responsible for providing accurate and complete personal and insurance information prior to being seen by the doctor. The charges made, for your visit and care provided, depend on the nature and the complexity of your problem.

**FORMS OF PAYMENT ACCEPTED:** Payment may be in the form of cash, checks, Master Card and Visa. Returned checks are subject to a service charge. Elective Cosmetic Surgeries may also be paid in full with a *Cosmetic Fee Plan* or *Patient Financing Services* account.

**PAYMENT FOR SERVICES (SELF-PAY/NON-INSURED):** Payment in full is expected before services are rendered unless prior financial arrangements have been made.

**PAYMENT FOR SERVICES (PERSONAL HEALTH INSURANCE/MEDICARE):** Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by your insurance company. In all cases, we require that the guarantor, the person who is financially responsible, is *personally* liable for all balances not covered by Medicare or other insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. All charges are your responsibility from the date services are rendered. **CO-PAYMENTS:** Co-payments are due at the time of service.

**PAST DUE ACCOUNTS:** Any balances on your account after 90 days, including those that insurance has not paid, will be referred to a collection agency unless other financial arrangements have been made in advance. Legal fees that we pay to secure any past due balances will be added to your account. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

**WORKERS COMPENSATION:** If you are seeking medical care as a result of a work-related injury, we will assist you in verifying your claim for the coverage of your medical bills. If for any reason your worker's compensation is not verified, the full responsibility for payment of services rendered will be that of the individual receiving treatment.

**PAYMENT FOR ELECTIVE COSMETIC SURGERY:** Payment in full is expected before services are rendered. Aesthetic (Cosmetic) surgeries will not be scheduled until your financial obligation has been met. Our office requires a minimum deposit of \$500 or 10% of the total surgeon's fee, whichever is greater, in order to schedule your surgery. This deposit will be applied to your "surgeon's fee" portion of the cost. Payment may be in the form of cash, checks, Master Card and Visa. If paying by credit card, the card must be presented in person by the authorized cardholder and a charge slip must be signed. Returned checks are subject to a service charge. Payment in full of the surgeon's fee must be received two (2) weeks prior to your scheduled procedure or we reserve the right to cancel or reschedule your surgery.

**CANCELLATION OF ELECTIVE COSMETIC SURGERY:** Should it become necessary for you to cancel or reschedule your surgery, we must receive notice of that change at least 10 days before your surgery date. If we receive notice of cancellation by that time, your deposit will be refunded in full. If you paid for your surgery with one of our financing companies offered, we will refund your financed portion of your payment minus 7%. If you should cancel your surgery three times, your deposit of \$500 or 10% paid will not be refunded and we will require a new deposit to reschedule your surgery. Exceptions will be made for documented emergency or medical disability.

**REFUNDS FOR SKIN CARE SERVICES/PRODUCTS:** Refunds will be made on pre-paid services that are not rendered, after regular prices are applied to those services already received. All SkinMedica home care products are 100% refundable within 30 days of purchase with receipt.

By signing this form, I fully understand and agree to the terms of the FINANCIAL POLICY.

Signed: \_\_\_\_\_ Print: \_\_\_\_\_ Date: \_\_\_\_\_

Office Signature: \_\_\_\_\_ Print: \_\_\_\_\_ Date: \_\_\_\_\_