Informed Consent

OUT-OF-NETWORK FINANCIAL RESPONSIBILITY

INSTRUCTIONS

This document describes your **out-of-network financial responsibility.**

Please read this information carefully. Initial each page once you read it. Then sign the consent form.

It is important that you read this whole document carefully. Please initial each page. Doing so means you have read the page. Signing the consent agreement means that you agree to the surgery that you have talked about with your plastic surgeon.

GENERAL INFORMATION

"Out-of-network" means that your doctor or facility is not under contract with your insurance company. They have not discussed rates for certain medical services. To know if a doctor is in your network, call the number on your insurance card. They can also tell you if you have out-of-network benefits.

If you do not have out-of-network coverage, your claim may be denied. You must pay any charges not covered by your plan. This may be the full billed amount.

You may go to a plastic surgeon by choice or on the advice of other medical professionals. Either way, check your plastic surgeon's network status before getting care. Most plastic surgeons don't work for a hospital and **may not be a part of** your insurance plan.

FINANCIAL ACCOUNTABILITY

The cost of any surgery includes the surgeon's fees, supplies, anesthesia, tests, and any outpatient charges. **You must pay for what your insurance does not cover. This could be co-payments, deductibles, and other charges.**

The fees for this surgery do not include costs for future surgeries. These may be elective or required to reach your desired outcome. Surgical problems may lead to more costs. Fees for a surgery done later should be borne by you.

FEE FORGIVENESS

Some out-of-network doctors and facilities may adjust your charges. They may accept the amount insurance plans pay in-network providers. To do so, you may need to pay out-of-pocket and then submit the claim. Your insurance plan may not accept this.

State laws may also forbid "fee forgiving." It may be illegal. Any doctor or facility adjusting the fee may face civil and criminal liability.

By signing this form, you confirm that you know about your surgery's risks. You accept responsibility for all financial costs.

☐ I am aware that the cost of surgery may be covered by my insurance. I am responsible for any co-payments, deductibles, and extra charges.

☐ I am aware that there will be a non-refundable fee for scheduling this surgery of $_____. This is part of the total fee.

This fee is to reserve time in the OR and in practice. You will lose this fee if you cancel your surgery without a medically acceptable reason. To approve a reason, you must submit it in writing within _____ weeks of surgery.

☐ I understand that I am must pay the surgical fees and those for anesthesia, the OR, lab, X-ray, and pathology. Surgical centers, outpatient centers, and hospitals often send certain tissues/implants for evaluation. This may result in more fees. Please check with your surgeon for an estimate of additional costs.

☐ I understand and accept the financial responsibilities listed above.

FINANCIAL AGREEMENT

If your insurance plan fails to pay the full fee, then you must pay the balance.

☐ I understand that any balance fee not paid by my insurance company should be paid by me. If my account needs to be placed with a collection agency because of any unpaid balance, I agree to pay $_____or _____% of the balance, whichever is greater.

☐ I request that payment for this treatment be made to Dr. Steve Sample. I authorize the provider of this service to submit a claim to my medical insurance company.

☐ I authorize Dr. Emil J. Kohan, M.D. or his agent to release my medical information (including HIPAA protected information) relating to this treatment. This may include insurance, other facilities, or any person responsible for paying my bill.

CONSENT

☐ **I have read the above information and understand the following.**

• For elective procedures, I may opt for a participating or non-participating doctor or facility.

• If I choose a non-participating doctor or facility, my insurance may not cover the services.

• If I use my plan's out-of-network benefits, I may have higher costs.

☐ I wish to use a non-participating doctor or facility. I understand what this means for payment.

☐ I acknowledge that I have a right to a copy of this form.

Patient signature_____ Date/Time_____

Print name_____

