

**GOLD COAST PLASTIC SURGERY LLC**

*Patient Financial Responsibility:* **SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_

I acknowledge full financial responsibility for services rendered by Gold Coast Plastic Surgery, LLC. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and co pays. I understand payment of co-pays is expected at time of service, as well as any prior balance I may owe. I also consent that the payment of authorized Medicare insurance benefits be made on my behalf directly to Gold Coast Plastic Surgery, LLC for any medical or surgical services furnished. I agree to all reasonable attorney fees and collections costs in the event of default of payment of my charges. You will receive a statement from our office indicating what your insurance has paid. Any balance remaining is due upon receipt. A valid credit card is required prior to services being rendered. Your credit card will not be charged until after the services provided have been processed by your health insurance carrier and the balance deemed patient responsibility. You will be notified by one statement only of any outstanding balances prior to us charging your card. Balance is expected within 10 days of receiving your statement.

*Consent for Record Release:* **SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_

I hereby give my consent to Gold Coast Plastic Surgery to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all protected health information in my patient record. For a more detailed description of this consent and other uses and disclosures please review Notice of Privacy Practices. I understand that Gold Coast Plastic Surgery reserves the right to change its privacy practices that are described in the Notice. I also understand that any Revised Notice will be available at the office and I may request a copy be sent to me by mail. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice to of my desire to do so. I also understand that I will not be able to revoke this consent in cases where Gold Coast Plastic Surgery, LLC has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the Gold Coast Plastic Surgery, LLC.

*Acknowledgement – Notice of Privacy Practices:* **SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_

I hereby acknowledge receipt of Gold Coast Plastic Surgery, LLC Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information. I understand that Gold Coast Plastic Surgery has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me.

*Office and Financial Policies:*

**Canceled Appointments:** If you are unable to keep your scheduled appointment, please call our office within 24 hours to notify us and reschedule. This will allow us time to use your slot for another patient.

**No Insurance:** Payment will be due at the time of service.

**Returned Checks:** A \$50.00 charge will be added to your account for any check returned by your bank for any reason.

**Disability or Insurance Forms:** There will be a charge of \$15.00- \$30.00 for the completion of medical forms (charge is based upon the number of pages and the complexity of the information requested). Payment is due prior to being mailed, faxed, or at the time you pick them up. Please allow 7- 10 business days for completion of these forms.

**Medical records:** There will be a charge for copying medical records within the Illinois State Statutes, **minimum charge is \$23.78**. An invoice of charges will be submitted to you and payment is expected prior to your records being mailed. You will need a signed letter of release. Please allow 14 business days for copies to be prepared.

*I hereby authorize payment of Medical/Surgical payments to George T. Moynihan, M.D., for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. A statement of charges will be mailed to you. Payment is expected within 10 days. In the event this account is assigned to collection, I agree to pay all costs of collection, including reasonable attorney's fees. I authorize the release of any medical information necessary to process claims.* **SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_