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|  | **Roberta L. Gartside M.D.**  *1800 Town Center Drive, Suite 412*  *Reston, VA 20190*  *Phone (703) 742-8004*  *Fax (703 ) 742-3749* |

Office Financial Policy

Effective January 1, 2015

Welcome to New Image Plastic Surgery Associates, PLC we are pleased you have chosen our practice. This information is to inform you in advance of our office financial policies. This policy serves to provide a clear understanding of your rights and financial responsibilities. Please feel free to discuss any additional questions with our staff. We look forward to providing quality medical care to you and help in any way we can.

You agree to provide the office with complete, accurate, and up to date insurance information. A valid insurance ID card, complete patient demographic form, and verification of eligibility and benefit coverage. You agree to authorize Roberta L. Gartside, MD, to release all necessary medical information to your insurance carrier necessary to complete payment of claims. You also authorize all medical benefits which are payable under the terms of your policy to be paid directly to Dr. Gartside.

All co-payments and deductible amounts are due and payable at the time of service per your contractual obligation with your insurance company. Payment in full is expected if you do not have insurance coverage, receive services for an uncovered benefit, or fail to furnish necessary insurance coverage documentation at the time of your visit.

You understand that your insurance is a contract between you and your insurance company, not between your insurance company and the doctor. You are fully responsible for all medical fees. Please carefully review your health insurance coverage and benefit policies. Your Insurance Carrier Member Services Department can provide you with a detailed listing and assist you in understanding your policy. In the unlikely event that your account is referred to collections, you will be responsible for all costs of collection that will be no less than 25% of the balance due plus the cost of court filing fees to enforce collection.

**Payments and Fees Policy:**

We accept cash, checks, Visa, Master Card, Discover or American Express Card for payment(s)

* **There is a $50 fee for returned checks, plus the original amount of the returned check.**
* **There is a $25 fee for no show/missed appointments or failing to provide 24 hours advance cancellation notice.**
* **There is a $600 surgical rescheduling fee if you fail to provide a 14-day advance notice and valid medical excuse.**
* **There is a 20% non-refundable deposit required when scheduling any cosmetic surgery. This fee is applied towards surgery and is non-transferable.**
* **Office based procedures (insurance or self-pay) may have a practice management fee associated with them and you will be informed prior to scheduling.**
* **There is a $30.00 fee for any forms that Dr. Gartside needs to complete/sign. (FMLA, Disability, Time off Work)**

I, <PersonalInfo.FirstName> <PersonalInfo.LastName>, certify that I have read, understand, and agree to all terms of the above office financial policy.

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Patient or Legally Authorized Individual Signature Date

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Printed Name/Name if Signed on Behalf of Patient Relationship (Parent, Legal Guardian, etc.)