

East End Plastic, Reconstructive, & Hand Surgery, P.C.
Judy Ann Emanuele, M.D., F.A.C.S.

Financial Policy

Thank you for choosing us as your health care provider. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

- **Our office only participates with Medicare, No Fault, Worker's Comp, MDNY, Oxford and United Healthcare.** All other plans are considered **OUT OF NETWORK**. Please check your policy regarding out of network benefits to become familiar with how they work. We would be happy to assist you with any insurance questions or needs.
- **I understand that although I may have insurance to cover the cost of services rendered, I am ultimately responsible for the payment of these services.**
- Co-pays and deductibles are due at the time of service for all patients. As a courtesy, we are able to bill some secondary insurances, please check with the billing office to see if yours is included. **We do not bill third and fourth insurance;** however, we will provide you with an itemized statement so that you may do so.
- Please be aware that certain procedures and/or treatments may not be considered by your insurance company to be medically necessary, and may not be covered. I understand that if these services are denied, I will be responsible for their payment.
- Full payment is due one week before any **surgery** for all **cosmetic and/or self pay patients** (unless special arrangements are made in advance).
- We accept cash, checks, Visa and MasterCard. Financing is available to those who qualify (ask for details).
- All returned checks will be subject to a \$30.00 service fee.
- All scheduled appointments that you are unable to keep and do not cancel 24 hours prior will be subject to a \$25.00 "No Show" fee.
- If for any reason your account goes to our collection agency, all courtesy adjustments applied to your account will be removed. Attorney fees of 1/3 your total balance plus any processing fees that may be incurred will be added to your account in order to collect payment in full.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the above Financial Policy. I understand and agree to this policy.

Patient/Responsible Party Signature

Date