

**PLEASE REVIEW AND SIGN**

All office visits are due and payable on the date service is rendered. If you have an insurance company that Heartland Plastic & Hand Surgery (HPHS) is a participating provider with, you will be responsible for paying your co-pay the day of your visit. A claim will then be submitted for you. No claim will be submitted for any cosmetic services, such as; Skin Care, Laser Treatments, Surgery, etc.

It is our policy to file all insurance claims for surgeries or hospitalizations. It is your responsibility to furnish our office with your insurance information. This office cannot accept responsibility for collecting your insurance claim or negotiating the settlement of a disputed claim since we are not a party to your insurance contract. You will be responsible for any non-covered services as stated by your insurance company. In accidents, legal cases, etc., where a third party is presumed liable for your medical expenses, the party receiving medical services is responsible for payment. This office cannot be expected to wait for court conclusions or disputed insurance claim settlements.

I understand that I am obligated to pay this account in accordance with the regular rates and terms of HPHS. If I fail to make payment after insurance pays and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies up to 40%. Such contingency fee is to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency. I also agree that any patient or guarantor overpayments to HPHS may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment.

In cases of workers compensation, we must have an authorization from your employer or the workers comp carrier. If your claim is denied, you are responsible for payment of medical services provided.

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims, credit card charges, and/or outside financing agencies and also to release to any physician that I request.

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS:** I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefit, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

**PRIVACY NOTICE ACKNOWLEDGEMENT:** I hereby acknowledge that I have been offered a copy of, and been given the opportunity to ask questions regarding, the facility's Notice of Privacy Practices. You agree, in order for us to service your account, notify you of information pertaining to your account or medical condition, or for the purposes of collection, we may contact you by telephone at any number provided by you, including wireless telephone numbers. We may also contact you via e-mail or text message using any email address you provide. Methods of contact may include the use of pre-recorded and artificial voice messages and/or use of an automated dialing device.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

---

**PATIENT RELEASE OF INFORMATION**

I hereby authorize Heartland Plastic & Hand Surgery to release my protected health information (PHI) to the person(s) that I have listed below. I understand that this authorization will remain in effect until I revoke it in writing to Heartland Plastic & Hand Surgery.

\_\_\_\_\_  
Spouse (Please PRINT Name)

\_\_\_\_\_  
Name of Individual (Please PRINT Name)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name of Individual (Please PRINT Name)

\_\_\_\_\_  
Relationship to Patient

**OR** ☐ I do not wish to name any individuals with whom my information may be shared.

\_\_\_\_\_  
Name of Patient (Please PRINT Name)

\_\_\_\_\_  
Patient's Acct No

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date