LOWCOUNTRY PLASTIC SURGERY CENTER, LLC

Statement of Financial Responsibility

I understand that it is my responsibility to supply LOWCOUNTRY PLASTIC SURGERY CENTER, LLC with any current insurance information and/or any referral authorization forms that may be necessary for my insurance**.** I am aware that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. If this account becomes delinquent, I understand that a billing charge ($25.00) as well as late fees and interest may be added to the balance due. In the case of default of payment, the undersigned guarantor agrees to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I authorize LOWCOUNTRY PLASTIC SURGERY CENTER, LLC to receive all payments for medical services rendered to my dependents or myself. These authorizations will remain on file for all future treatment. I AM AWARE THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCES.

Reconstructive procedures are typically covered by insurance; however, this coverage cannot be determined until preauthorization is filed with your carrier. Prior authorization will allow you to better understand both your coverage and your financial responsibility.

I understand that Medicare and most insurance companies do not cover cosmetic surgical procedures or office visits. I also understand that my insurance carrier may consider some services performed by LOWCOUNTRY PLASTIC SURGERY CENTER, LLC as "not covered." Therefore, I will be fully responsible for payment of these charges. I also understand that insurance companies require beneficiaries to pay deductibles, company insurance, co-payments, and any non-covered services at the time services are rendered.

IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. WE GLADLY ACCEPT CASH, CHECK, AND CREDIT CARDS. NO REFUNDS OR EXCHANGES ON ALL PRODUCTS OR SERVICES PURCHASED. ALL RETURNED CHECKS ARE SUBJECT TO A $25.00 service charge. I am aware that I am responsible for any portion of my charges not paid by my insurance carrier, and that a finance charge may be assessed on any balance over 90 days delinquent.

Notice of Privacy Practices Acknowledgement

We are required to provide a Notice of Privacy Practices to you by the Health Insurance Portability and Accountability Act (HIPAA). My signature below constitutes my acknowledgement that I have received the Notice of Privacy Practices and have been provided an opportunity to review it. I further authorize Lowcountry Plastic Surgery to contact my emergency contact as needed.

Release of Information

I authorize LOWCOUNTRY PLASTIC SURGERY CENTER, LLC to obtain information from other physicians that they may feel is beneficial in their evaluation or treatment. I authorize the physicians of LOWCOUNTRY PLASTIC SURGERY CENTER, LLC to furnish information to insurance carriers or other doctors concerning my illness and treatments. They may also obtain pre-certification, preauthorization, and predetermination when necessary.

Patient's Name: _____Birthdate _____

Signature: _____Date: _____

If Legal Guardian, Relationship to Patient _____