Financial Policy

We at Renaissance Plastic & Reconstructive Surgery, PA are dedicated to providing you with the best possible care and treatment and regard your understanding of our financial policy as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with my staff.

Your insurance contract is an agreement between you and your insurance carrier. Although we participate with many plans, it is the patient's responsibility to make payment in full should we not participate with your plan. As a courtesy, we will file your insurance on you behalf. Variations to this policy will be considered prior to services being rendered on a case by case basis. For patients enrolled in plans with which we participate, co-pays and deductibles are due at the time of service.

A $25.00 returned check fee will be assessed to your account for every check returned to Renaissance Plastic Surgery, PA for insufficient funds. Patients issuing two (2) NSF checks must make all future payments by cash or money order.

We reserve the right to turn any patient over to collections if it is deemed that the account has been in default of payment obligations or for noncompliance of the policy. If we turn your account over to a collection agent, you will be responsible for administrative fees. Patients previously sent to collections are required to pay old balances in full and for all future visits. Patients who do not comply with policy may be dismissed from this practice. Only emergency care will be provided for a 30 day period after dismissal, at which time the patient should have been established with a new physician.

For all services rendered to minor patients, the adult accompanying the patient is responsible for the payment.

I have read and understand the financial policy of this practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by this practice. I hereby authorize Renaissance Plastic & Reconstructive Surgery, P.A. to release information acquired in the course of my examination/treatment to my insurance carrier for payment directly to Renaissance Plastic & Reconstructive Surgery, P.A. I agree to be responsible for payment of services determined not to be medically necessary or non-covered by my insurance carrier.

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Signature of Responsible Party Date