Associated Plastic Surgeons & Consultants, P.C.
Cosmetic & Reconstructive Plastic Surgery
* Diplomates American Board of Plastic Surgery
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864 West Jericho Turnpike
West Hills, New York 11746
631-423-1000
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I hereby give Associated Plastic Surgeons & Consultants (APS&C) permission to render plastic surgical evaluation and treatment to

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I fully understand that Plastic Surgery involves a level of care and service that may be different from that usually provided by a hospital emergency room and that my insurance provider may not reimburse all or any part of the fees for services rendered. Payment, therefore, is agreed to be my personal responsibility. The hospital's fee is separate and distinct from the plastic surgeon's fee.

I understand that APS&C will assist me in the filing of necessary insurance claim forms, however payment is agreed to be my responsibility.

If, by a special written arrangement with APS&C, signed before the procedure is performed, APS&C may agree to accept the insurance allowance from my insurance company as payment in full. I understand that the insurance allowance may be more than the actual amount received from the insurance company and in that event, I agree to be responsible for the difference.

My insurance company may, for example, subtract my deductible and co-insurance (contractual obligation, co-payment, etc) from their insurance allowance reimbursement. My insurance company may down-code or reimburse for certain services rendered. It is, therefore, agreed that these charges remain my personal responsibility to APS&C.

Legal fees associated with a delinquent account are also my responsibility. In the event my account goes into collection, I will be responsible for a service fee of $250.00 or 33% on the unpaid balance whichever is greater. This fee is in addition to all legal fees previously mentioned. On delinquent accounts greater than 60 days from the date services are rendered, interest will be charged at the rate of 1.25%/month.

By my signature below, I agree to all terms and conditions outlined above.

_____ _____
Patient/Parent/Guardian Date

_____
Print Name

_____ _____
SS# Date of Birth