RM | ROBERT MORIN MD
PLASTIC SURGEON

FINANCIAL RESPONSIBILITY CONSENT FORM

Insurance Coverage:

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by the insurance carrier. Please contact your insurance carrier with any questions regarding your coverage.
- We make every effort to verify that your insurance is valid at the time of your visit. However, please understand that if your coverage has been terminated or suspended at the time of visit, you will be financially responsible for payment of services rendered.
- If your insurance changes, it is your responsibility to notify the office prior to your next visit so we can make the appropriate changes to help you to receive your maximum benefits.
- Verification of benefits with your insurance carrier is not a guarantee of payment for claims submitted by our billing company.

Office Policies:

- Post - operative office visits (for non-cosmetic surgery and emergency procedures) are not always included as part of the surgery fee. Surgery package guidelines vary based on the procedure performed.
- Post- operative cosmetic surgery office visits are included as part of the surgical fee.
- I have been informed that Dr. Robert Morin may not participate with my insurance plan. If I have No Out-of-Network coverage for non-emergent services, I am aware that my insurance carrier will not pay for my services rendered.
- If I have Out-of-Network coverage for non-emergent services, I am aware that my insurance carrier may pay benefits at a reduced rate.
- I accept financial responsibility for services provided to me by Dr. Robert Morin.

Deductibles:

- Deductibles are the patient's responsibility. The deductible is determined by the contract that you have with your insurance company. Our office does not know and is not responsible for knowing how much each patient's deductible is or how much has been met at the time of your visit.

Referrals:

- It is your responsibility to verify with your insurance carrier if you require a referral prior to your appointment. If you require a referral, it is your responsibility to obtain the proper referral prior to your appointment.

Release of Information:

- In connection with the medical services that I am receiving, I hereby authorize the release of my information and medical records, including copies of applicable hospital and medical records to:
- A. Any third-party payer covering the medical services of the patient
- B. Other health care professional and institutions involved in the delivery of health care to the patient
- C. The proponent of any legally sufficient subpoena, or in response to a court order
- D. Employees and agents of the practice, to the degree necessary to facilitate the provision of healthcare services and payment for such services
- E. Pharmacies
- F. As otherwise required by law

Insurance Request:

- It is your responsibility to comply with any request from your insurance carrier for further information. Your inability to provide the requested information will result in a denial of your insurance claim and you will be responsible for the outstanding amount.
- You agree to cooperate with our billing company if they request your assistance in appealing your claim to your insurance carrier.

Insurance Payments issued and sent to you:

- If insurance payments are sent to you, it is your responsibility to forward the payment to our office upon receipt with a copy of your "Explanation of Benefits" (EOB) received.

Collection Accounts:

- In the event that your account is forwarded to our attorney/collection agency you are responsible for payment of attorney, collection agency and court fees if applicable.

We emphasize that as a medical care provider that our relationship is with you, the patient, and not with the insurance company. We will assist you in understanding your insurance policy and coverage.

I, _____, have read and understand my financial responsibility and agree to abide by the above stated guidelines:

Patient Name_____

Patient/Parent/Guardian Signature _____

Date_____