Cascadian Plastic Surgery PLLC
Jungwon Genevieve Park, MD, PhD
14 N Mission St Ste 201
Wenatchee, WA 98801
(509) 596-0096

# PATIENT FINANCIAL AGREEMENT

Cascadian Plastic Surgery PLLC

Thank you for choosing Cascadian Plastic Surgery PLLC ("Practice"). The following are important to know before receiving care at the Practice.

The patient is financially responsible for the payment of all services that are rendered on their behalf (or on behalf of dependents) by the Practice.

I. Medically necessary services
   A. The patient's insurance plan determines whether or not a procedure is considered medically necessary.
   B. Some services are almost always considered cosmetic (and not medically necessary). These services are billed to the patient, with payment due at the time of service.
   C. Some services may be considered medically necessary, but are not covered by the patient's insurer. The patient is financially responsible for payment of these services.
   D. Fees for cosmetic services differ from medically necessary services.

II. Cosmetic or self-pay services
   A. The Practice will provide a quote for self-pay services before they are rendered.
   B. Fees for cosmetic or self-pay services are due before the time of service.
   C. A nonrefundable deposit is required to hold an appointment.
      1. $50 nonrefundable deposit is required for a clinic appointment
      2. $500 nonrefundable deposit is required for a surgery appointment

III. Insurance participation, submission of claims, and patient payments
   A. It is the patient's responsibility to provide a copy of their (or their dependent's) active medical insurance cards for the Practice's records at the time of service. The patient will immediately notify the Practice of any changes in coverage or loss of coverage.
   B. The Practice will inform the patient if it is out of network with their plan.
   C. If the Practice is out of network with the patient's insurance plan, we will assume that the patient responsibility is 100% and ask for this to be paid at the time of service, unless otherwise agreed upon. An exception to this is if the patient has a plan that does not allow the Practice to take payment for a service that would be covered by an in-network provider.
   D. If the Practice is in network with the patient's insurance plan, we will send a claim to the insurance plan, and the plan will determine the allowable fee and the patient's responsibility (co-pay, co-insurance, deductible). The Practice will then collect any remaining balance of the patient's responsibility as determined by the insurer, or return any overpayments.

E. The patient will inform the Practice, at the time of service, if they do not want the Practice to submit claims on their behalf.

IV. Prior Authorization for medically necessary services/procedures
   A. Some insurance plans will require prior authorization for medically necessary services. It is the patient's responsibility to determine if prior authorization is needed. The Practice will make a reasonable effort to request prior authorization based on readily available information about the insurer's policies.
   B. Prior authorization is not a guarantee of payment by the insurance plan.
   C. The patient is financially responsible if the insurer denies payment for services.

V. Good Faith Estimate (GFE)
   A. The GFE shows the fees that are reasonably expected for an item or service, including surgical fees. Upon request, a patient will be provided a GFE prior to receiving items or services that are:
      1. Cosmetic and not medically necessary, or
      2. Medically necessary but provided by an Out-of-Network provider/facility
   B. Medical necessity, in this context, is determined by the patient's specific insurance plan.
   C. The GFE does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, and your bill is $400 or more for any provider/facility than your GFE, federal law allows you to dispute the bill.
   D. The GFE is not a contract and does not require the patient to obtain the items or services from any of the providers or facilities identified in the GFE.

VI. Collections
   A. If the patient fails to make any payment due and owing to the Practice, the Practice reserves the right, in accordance with applicable law, to assign the patient's account to a collection agency. To the extent permitted by applicable law, the Practice may require the patient to pay the collection agency fee, and all other costs and expenses, including but not limited to reasonable attorney's fees and court costs, necessary for the collection of the patient's delinquent account.

VII. Facility and Other Fees
   A. The patient may receive separate bills for other services or items related to the service(s) provided by the Practice. These bills could be from a hospital/facility, anesthesia provider, laboratory, pathology, radiology, and other consulting providers.

VIII. Refunds
   A. Overpayment refunds will be made promptly by check or credit card.

IX. Cancellations and missed appointments

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A. The patient should give the Practice at least 24 hours notice for any cancellations.
B. A pattern of repeatedly missing appointments may result in termination of the patient from the Practice.

## Patient Acknowledgment

By my signature below,

I, _____, have read and understand the Patient Financial Agreement of Cascadian Plastic Surgery PLLC. I agree to be financially responsible for all charges not paid by my insurance carrier or other third-party payer.

I represent and warrant I have the legal right to sign this Patient Financial Agreement because I am the patient, or I am the parent or legal guardian of the patient who is authorized to consent to health care on behalf of the patient.

In the event that my insurance covers all or part of the services rendered to me by Practice, I hereby authorize the Practice, as a courtesy to me, to submit claims for payment to my insurance company. I authorize my insurance company to pay, and send payment directly, to the Practice for services provided. I request that payment of my Medicare, Medicaid, and other health insurance benefits be made on my behalf to Practice for services furnished to me by Practice and its providers. I hereby authorize the Practice, its agents, and any other holder of medical information about me, to release to my health insurer, including but not limited to the Centers for Medicare and Medicaid Services and its agents, any information needed to determine such benefits or the benefits payable for related services.

_____ _____

Patient Signature Date