Oxford
PLASTIC SURGERY™

Dan H. Shell IV, M.D., PLLC

Financial Policy

Unless prior arrangements have been made with your doctor, we ask for full payment for your office care at the time office services are rendered. We accept cash, cashiers check, money order, personal check, MasterCard, Visa and Discover. As a service to you, we will be happy to file an insurance claim for you at Dr. Shell's discretion on any insurance approved procedure.

It is the policy of this office to collect the patient's deductible if it has not been met for the calendar year before surgical procedures are performed. For procedures covered by your insurance we will submit a claim to your insurance company, and once the company has paid all it will pay on the claim, the adult patient (18 years of age or older), or guarantor is responsible for any remaining balance. Any services not covered by insurance plans are to be paid in full prior to surgery. There is a processing fee of $40.00 on all returned checks.

We have found that many insurance plans provide payment at levels significantly lower than our fees. We take great care in setting our charges well within the acceptable norms for similar services in this area. Insurance companies no longer abide by these norms, rather they establish their own reimbursement schedules. If you find that your insurance plan does not cover certain services or that it pays below our usual charge, we encourage you to discuss this with your insurance carrier.

It is our desire that you receive the maximum benefit possible from your health insurance. In order to achieve this we need your assistance in providing us complete and accurate personal and insurance information on the attached form.

We participate in numerous insurance programs to accommodate our patients. While we are pleased to be able to provide this service, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each plan has different policies regarding how often services may be rendered and, even more importantly, where those services may be performed. We ask you to inform us if your coverage has any special requirements, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have not choice but to bill you directly for those charges.

As a courtesy to our patients, we have a waiting list for appointment availability. As a policy, we ask that you contact our office at least 24hrs prior to your scheduled appointment if you need to cancel or reschedule so that we may offer the appointment time to another patient. If you fail to cancel and no-show, there will be a fee incurred of **$75**. According to the Medicare guidelines, a fee can be charged for a no-show appointment due to a missed business opportunity. We appreciate our patients and would like to thank you for your consideration of our policies.

As a policy, a non-refundable reservation fee is charged for booking in office cosmetic procedures, injectables, and fillers at the time the appointment is made in the amount of $100. The reservation fee will be applied to the balance of the procedure performed at time of treatment. In office cosmetic procedures are charged at the rate of $500 for up to the first hour of time required and $250 for each additional 30 minute increment needed.

We ask you to remember that the ultimate responsibility for full payment for our services rest with the adult patient or guarantor. If your account becomes delinquent and it becomes necessary for the account to be referred to an attorney or collection agency or suit, I as the designated responsible party or entity shall pay all patient charges reasonable attorney fees and collections expenses.

I have read and understand this explanation of the financial policy of Dan H. Shell IV, M.D., PLLC and agree to accept responsibility as described.

Adult Patient/Guarnator:____Date:___________________

Insurance Authorization and Assignment

I hereby authorize Dan H. Shell IV, M.D. to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to be or my dependents. I understand that I am responsible for any amount not covered by insurance.

Adult Patient/Guarntor:____Date:____________________

Medicare – Medicaid Certification

I authorize any holder of medical information about me to release to the Social Security Administration or it s intermediaries or carries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Dan H. Shell IV, M.D. for services rendered me by its physician(s).

Patient or Representative:____Date:_____________________