Ambulatory Plastic Surgery Center Associates, CHTD
Statement of Patient Financial Responsibility

Patient Name: _____DOB: _____

Ambulatory Plastic Surgery Center Associates, CHTD appreciates the confidence you have shown in choosing us to provide for your health care needs. Our practice participates with almost all insurance plans. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage, preauthorize your surgery as possible and bill your insurance carrier on your behalf. Please note that preauthorization is not an absolute guarantee of payment and that you will be responsible for charges not covered by your insurance company.

Your health insurance policy is a contract between you and your health insurance company or your employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for **referrals**, pre-certifications, pre-authorizations, limits on outpatient charges, and any requirements for specific physicians, labs and/or hospitals to use. We encourage you to contact your insurance company if you have any questions regarding your benefits, copays, or deductibles. You are responsible for payment of any **deductible and co-payment/co-insurance** as determined by your contract with your insurance carrier. Some insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. Our office includes a fully accredited surgical center that meets the same strict outpatient standards similar to hospitals. Just like at the hospital, there will be a separate facility fee for all surgical procedures.

I have read the above policy regarding my financial responsibility to **Ambulatory Plastic Surgery Center Associates, CHTD**, for providing services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my primary insurer and/or secondary/tertiary insurer to pay any benefits directly to **Ambulatory Plastic Surgery Center Associates, CHTD** or my physician, the full and entire amount of bill incurred by me or the abovenamed patient. I understand that I am financially responsible for all charges incurred by me not covered by my insurance and any and all legal/collection fees that may be required in their collection.

Patient/Guarantor Signature _____Date_____

Advanced Directives

Do you have an executed Advanced Directive? Yes___No___

If you answer yes to the above, you are encouraged to bring the Directive with you.

Every patient and/or patient representative has the right to make informed decisions regarding your patient care and/or the care of the patient that you represent. Our office can assist you with a copy of the Maryland Directives Form and Planning Guide. However, our center does not recognize advance directives. If an untoward event were to occur, our policy is to perform full CPR per ACLS guidelines and transfer the patient to the nearest hospital (Adventist HealthCare Shady Grove Medical Center)

Patient/Guarantor Signature_____ Date_____