KITTO PLASTIC SURGERY
Inzhili Kitto M.D.

Plastic, Aesthetic & Reconstructive Surgery

FINANCIAL POLICY

Please complete all forms in its entirety. Be sure to initial at the bottom of each page prior to proceeding, in acknowledgement that all of your questions pertaining to the form have been answered.

Please initial on each line.

_____ **Mutual respect of time.**
We pride ourselves on punctuality at Kitto Plastic Surgery. Although there can be emergency situations that are out of our control resulting in us running behind schedule, we pledge to provide quality care with minimal wait times to the best of our ability. In order to respect your time, we make the following requests:

1. Arrive early or on time for your appointments. We may have to reschedule or squeeze you in whenever there is space if you arrive more than 15 minutes late.
2. We will provide you with all the time you need, but you must tell us when making the appointment ALL of the reasons you would like to be seen. This prevents us from running out of time and having to schedule another appointment to address other concerns.
3. If you are running late, call the office. We may be able to accommodate you with advanced notice.

_____ **Payment is required at the time services are rendered.**
This includes co-payments and payments for services not covered or denied by your insurance company.

_____ **Referrals.**
If you are enrolled in a managed care plan, a referral from your primary care physician to Kitto Plastic Surgery must be received by our office for your services to be covered under your insurance. Retroactive referrals are not allowed. If your referral is not received in our office prior to your appointment, we may have to reschedule your appointment. It is recommended that you verify that a referral has been received by our office at least 2 days prior to your appointment.

_____ **Self-pay accounts.**
If you do not have insurance or if this is an aesthetic visit, please come prepared to pay for your visit in full. For finance options please visit Prosper Healthcare Lending: https://www.prosper.com/borrower/apply/funnel/registration?type=phl&provider_id=032700&version=pad_no_ls

_____ **Copayments.**
We are required by our insurance contracts to collect all co-payments at the time of service. Not doing so is a violation of our contract with your insurance company, therefore we cannot "waive" copays.

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_____ **Missed appointment fee.**
Missed appointments represent a cost to us, you and other patients who could have been seen in the time set aside for you. Cancellations are required 24 hours prior to the appointment. Appointments not cancelled 24 hours in advance will result in a "No Show" fee of $50. This fee must be paid before a new appointment is scheduled.

_____ **Credit Card on file policy for commercial insurance.**
As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit. As a result, we offer the convenience of securely storing credit or debit card numbers on file with our office. Please be assured that this payment method will in no way compromise your ability to dispute charges or question your insurance company's determination of payment. If you have questions about this payment method, do not hesitate to ask.

I have read the Office policy as outlined above and understand the consequences. I also understand that I am ultimately responsible for the charges incurred.

Kitto Plastic Surgery accepts **debit cards, Visa, Mastercard, Discover, and Money Orders.**

PLEASE BRING YOUR CURRENT INSURANCE CARD TO EVERY VISIT.

Therefore, knowing this, I request that services be performed, and I agree to be responsible for any charges incurred. I understand that if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency, the undersigned shall pay all collections agency fees, court costs and attorney fees, and risks being dismissed from the physician care of Kitto Plastic Surgery.

By my signature below, I authorize the release of information necessary to file a claim(s), with my insurance company(ies) and assign benefits otherwise payable to me, to the provider, or the group indicated on the claim. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the full payment or balance as allowed on my account. I understand co-payments, deductibles, and payments for services not covered or denied by the insurance company are due at the time of service. I understand that if my account goes to collections, I shall pay all collection fees and costs incurred by Kitto Plastic Surgery. I certify that this information is true and correct to the best of my knowledge and will notify the office of any changes to my information, such as, but not limited to change in address, telephone numbers, insurance coverage, etc. I have read, understand and agree to abide by the Financial Policy.

Patient Name: _____ Signature: _____

Date: _____