

# David E. Berman M.D., FRCSC

## Financial Policies

The fees quoted for cosmetic surgery are inclusive of the following: Your pre-operative examination, surgical costs, anesthesia and facility, most supplies, and your pre and post-operative visits. Fees for in-office treatments such as Microdermabrasion, BOTOX, Restylane, or other filler material, chemical peels, laser hair removal, vascular lasers, and other similar procedures are priced either on a per treatment basis or as a treatment package option. A thirty percent (30%) cancellation fee exists for any of these unused package procedures, in addition to the charging for the services already rendered. Office treatments are payable in full three weeks from your appointment. Reservations may be confirmed with a credit card.

If you elect to have surgery, you may schedule it as soon as you like. This will improve your chances of getting the date that works for you. Professional fees are due three-weeks prior to surgery. Your time will be held for you until three weeks before your surgery date, with a deposit. If you have not made your payment before the three-week deadline, your time slot will be given to another patient on the waiting list. If your surgical booking is within 3 weeks of surgery, then payment is to be made by a cashier's or bank check. After booking, there is a thirty percent (30%) non-refundable cancellation fee, if cancellation occurs less 2 weeks before surgery.

Please complete financial arrangements at least three weeks prior to your surgery date. Patients interested in our financing options should speak with the staff before making surgical arrangements.

## Insurance Patients

This office does NOT participate with insurance companies. We are NOT a participating provider with most insurance companies. It is your responsibility to find out, in advance, what your particular plan covers for non-participating providers of your plan. Since we are NOT a participating providers in your network, then you are responsible for your bill in its entirety and we will provide you the necessary paperwork and assist you with filing your insurance claim so that you may be reimbursed from your insurance company directly.

Please refer to the back of your card for a contact phone number to get additional information. If we may be of assistance, please contact us. However, it remains your financial responsibility for complete payment if you are seen and/or treated.

## Workman's Compensation Patients

The workman's compensation system requires that you and/or your employer provide the office with your claim number and all necessary information for the office to process your claim. This will avoid any problems with your care delivery and claim processing.

## Billing Policy

### Non-covered Insurances

You are responsible for your office visits and surgical fees. We will provide you with a receipt of your visit, so you may forward this to your insurance company for reimbursement. Some insurance companies pay 100% of the surgical fee, others pay only a percentage. You will be receiving complete, partial or no reimbursement depending on your insurance plan you have.

### Assignment of Benefits

I, the undersigned, hereby authorize payment of medical and surgical benefits directly to David E. Berman M.D.

I, the undersigned, have insurance with and assign directly to David E. Berman M.D. all benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions.

Signature of insured or responsible party: \_\_\_\_\_ Date: \_\_\_\_\_

### Statement of Financial Responsibility

I, the undersigned, have read the above and realize that all medical and surgical charges incurred by me or my dependents for services rendered by David E. Berman M.D. are my financial responsibility. All court fees or other fees necessary to collect this account are payable by me.

Signature of insured or responsible party: \_\_\_\_\_ Date: \_\_\_\_\_  
David E. Berman, M.D.