PATIENT ELIGIBILITY WAIVER & FINANCIAL RESPONSIBILITY FORM

PATIENT NAME: _____ DOB: _____

The purpose of this form is to help our patients understand about medical insurance, eligibility, coverage, our office policy and medical services. Renue Plastic Surgery participates in an Organized Health Care Arrangement (OHCA) with Renue Surgery Center, LLC and Renue Surgery Center of Waycross, LLC; therefore, this Patient Eligibility Waiver & Financial Responsibility Form applies to EACH of these entities.

It must be understood that:

- We render our services on the basis that insurance companies may or may not pay for all, or a portion of our charges.
- Authorizations for medical treatment from your insurance company/doctor do not guarantee full payment for the service.
- Not all insurance companies/third party payors pay for all services, each policy has its own particular stipulations regarding covered services, or amount of coverage.
- All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received.
- Patients are personally responsible for knowing and understanding their own insurance policy, including co-payment, deductible, eligibility and coverage.
- Patients are responsible for payments of outstanding deductibles and co-payments at the time of service.
- Patients are financially responsible for payments of all non-authorized procedures and non-covered services.
- Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.

The Patient or Patient's Legal Representative hereby acknowledges that he/she is eligible for health insurance benefits and coverage. That in the event of ineligibility for coverage of plan benefits, as well as all non-authorized procedures and non-covered services, he/she understands and agrees to be fully financially responsible for payment of all costs incurred during the delivery of health services, and agrees to pay all charges to the Physician and/or Facility accordingly.

Patient / Legal Guardian Signature _____ Date _____

PATIENT'S AUTHORIZATION FOR SERVICES

I request that payment of authorized Medicare/Other insurance company benefits be made on my behalf to Renue Plastic Surgery / Renue Surgery Center / Renue Surgery Center of Waycross for any services furnished me by the provider/facility who accepts assignment. I understand it is mandatory to notify the health care provider for any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 USA 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits apply.

Patient / Legal Guardian Signature _____ Date _____