GOLDEN ISLES CENTER FOR PLASTIC SURGERY, PC
DIANE G. BOWEN, MD

FOR OUR PATIENTS WHO HAVE INSURANCE COVERAGE

INSURANCE COVERAGE IS A CONTRACT BETWEEN THE PATIENT AND THE INSURANCE CARRIER. Our office can only supply information to facilitate processing of your claim. Any discrepancies in reimbursement amounts therefore are the responsibility of the patient to resolve.

GOLDEN ISLES CENTER FOR PLASTIC SURGERY, P.C. IS NOT OBLIGATED TO FILE INSURANCE. Filing insurance for our patients is a courtesy we frequently undertake. We verify insurance benefits, we obtain pre-approval and/or pre-certification when necessary. However, at times, in spite of our best efforts, insurance carriers can misquote/misrepresent patient benefits. We recommend that our patients check their own policies or check with their insurance carriers.

PAYMENT OF BILLS IS ULTIMATELY THE RESPONSIBILITY OF THE PATIENTS. We would appreciate very much if our patients respond promptly to the insurance companies' request for information. Any unnecessary delay in claims processing secondary to a patient's failure to respond to the insurance company will result in the need to immediately pay his/her bill to Golden Isles Center for Plastic Surgery.

OUR OFFICE REQUIRES A TIMELY PAYMENT OF ANY BALANCES that are due after payment has been received from the insurance company. All balances should be paid within 90 days of your surgical procedure. Payments can be made by cash, check or credit card – VISA or Mastercard. Our insurance department will be available for questions about balances and payments

If you would like for your balance to be charged to your credit card please circle YES NO
If YES then please provide the following: MC VISA Card # Expiration Date

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize Golden Isles Center for Plastic Surgery, PC to furnish information to insurance carriers concerning my illness and treatments. I consent and understand that Dr. Bowen uses both medical and surgeon assistants as needed to provide the highest level of care. I hereby assign to the physician(s)/assistants all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. Interest will be charged on all unpaid balances at the rate of 1.2% per month. I also understand that this account will be placed with a collection agency after 120 days, and that I will be responsible for all collection costs as allowed by Georgia law.

I, the undersigned, have read the above statements and agreed to abide by the conditions stated.

SIGNATURE **DATE**