San Juan Plastic Surgery
Todd Williams, MD
Adams Plastic Surgery
Jason P. Adams, DO
2300 E. 30th Street Bldg B, Suite 103
Farmington, NM 87401

Financial Policy

Payment for services rendered is due in full at the time service is provided.

We bill most insurance carriers for you if you provide us with the proper information. Co-payments, co-insurance, and deductibles **are due at the time of service**. **Co-payments are the patient's responsibility even if the patient has secondary coverage. Typically we do not bill secondary insurances for co-pays due to additional financial expense to the practice.** Your agreement with your insurance is a private one. If your insurance carrier has not paid us within 45 days of billing, the fees are due and payable in full from you. If you belong to a managed care plan, HMO, or PPO, and have not been referred by your primary care provider (PCP), you may have reduced benefits or no benefits at our facility. It is your responsibility to obtain any required referrals. We **do not** participate with **Tri-Care, Tri-West, SCI groups, or the Veteran's Administration**. **ALL BILLING RESPONSIBILITIES WILL BE THE RESPONSIBILITY OF THE PATIENT FOR TRICARE, TRI-WEST, SCI GROUPS AND THE VETERAN'S ADMINISTRATION, HOWEVER THE OFFICE WILL GLADLY ASSIST IN THE NEEDED PAPERWORK FOR BILLING**. We do accept assignment from Medicare and will bill your Medicare claim for you.

If your condition is work related, we will, after verification, bill your worker's compensation carrier for the treatment provided to you. It is your responsibility to provide us the correct billing information. If the information is not provided or if the claim is denied, you will be responsible for payment of service.

If you are involved with a personal liability situation (third party auto accident, personal injury, ect. or have retained the services of an attorney, you will be responsible for your bill at the time of service. We will file insurance claims for you, but the insurance will pay you directly for those services. We will accept a "letter of protection" from your attorney, but you will be required to make reasonable payments until your claim has settled.

****Any additional paperwork requested by the patient concerning disability claims, work related issues, or family leave act will be charged an additional fee of $25.00 for the first form and $10 for each additional form and there will be a minimum of a one week wait for the completed paperwork.****

We accept cash, checks, MasterCard, and Visa. We recognize the unique and unanticipated nature of medical expenses and make available a flexible payment arrangement to assist special patient needs. Our accounts Management Representative can assist you with these payment options.

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You may be contacted by a letter or by telephone if your account becomes past due. If you fail to respond to our requests for payment, your account may be referred to an outside collection organization. If that occurs, you may incur additional costs and you may be reported to a national credit-reporting agency.

Some services such as specialist consultations, pathology, laboratory, interpretation of radiological studies, anesthesia, and hospital or surgery center operating room charges will result in billings from those specialists in addition to the bill from this office.

****After missed (NO SHOWS) or cancelled appointments you could be charged a NO SHOW fee of $35.00. If there is continued inconsistency in keeping scheduled appointments a permanent discharge from the practices could occur.****

****For ALL Medicaid patients: I hereby certify that I have NO other insurance coverage at this time and pledge to provide the office with any and all possible changes for any and all future care rendered by Dr. Williams or Dr. Adams. Anything other than FULL disclosure could result in the risk of insurance fraud and result in legal penalties and loss of insurance coverage. _____**

I have read, understood, and agree to this financial policy. I understand that I am ultimately responsible for my bill.

_____ _____
Signature of Patient/Responsible Party **Date**

_____
Printed Name