THE NEW YORK
AESTHETIC CONSULTANTS
PLASTIC, LASER & DERMASURGERY

DERMASURGERY
RON M. SHELTON, M.D., F.A.A.D.

NEW YORK OFFICE-BASED SURGERY, PLLC

PLASTIC SURGERY
TED CHAGLASSIAN, M.D., F.A.C.S.
WILFRED BROWN, M.D., F.A.C.S.

MEDICAL FINANCIAL POLICY FOR SELF-PAY PATIENTS

Welcome and thank you for selecting the New York Aesthetic Consultants (NYAC). We wish to provide you with the best possible administrative, medical and surgical care. It is our desire to be as attentive as possible to your financial needs. Dr. Ron Shelton, Dr. Ted Chaglassian, and Dr. Wilfred Brown do not participate with any commercial insurance company. Please refer to the Patient Demographic Information form for details on other The NYAC financial policies.

Please note:

- The NYAC will request payment in full on the day of the procedure.
- The NYAC accepts payment by cash, check, MasterCard, Visa, Discover, American Express, or financing through CareCredit. Checks must be made payable to The New York Aesthetic Consultants, LLP.
- If you have health insurance coverage, we will give you a CMS-1500 form to submit for reimbursement.
- Prior to the service, we will confirm your benefits, pre-certify medically necessary surgical procedures, and give you an estimated cost of the procedure.
- Pre-certification is not a guarantee of payment to you by the Insurance Company. The insurance coverage is a contract between you, your employer, and the insurance company.
- To the extent any sums due and owing are not obtained at your time of visit and are deferred, you understand that you will be responsible for any and all costs, fees and attorney's fees associated with collection thereof.
- If you have questions regarding this policy, please ask to speak to a billing representative Monday through Friday 9am-5pm.

Mastercard_____ Visa _____ American Express _____ Discover _____

Card #_____

Exp_____/_____Security ID # (3-4 digits, on back of card) _____

Card Holder _____ **I hereby authorize The NYAC to charge my credit card and hereby confirm I will not dispute this charge with my credit card company. Signature_____**

By signing below, I acknowledge I have read and agree to the above policy terms and conditions.

Patient Name: _____

Patient/Legal Guardian Signature: _____Date: ____/_____/_____