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.

MEDICARE FINANCIAL POLICY

Welcome and thank you for selecting the New York Aesthetic Consultants. 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.

ALL MEDICARE BENEFICIARIES are required to pay the annual deductible. After the deductible is met, Medicare will pay 80% of their allowed amount. Under Federal law, we must bill a patient the 20% remaining balance that is called "co-insurance". If a patient has a supplemental insurance policy to Medicare, it may cover this 20% co-insurance. However, if a patient has a secondary policy with any commercial insurance, it may deny the co-insurance payment because our providers do not participate with any commercial insurance plan. As a courtesy we will file a claim with the secondary insurance. If co-insurance payment is not received within 30 days or if the claim is underpaid, the balance will be patient's responsibility.

If a patient has **Oxford** or **United Healthcare-Empire Plan** as a secondary insurance, the co-insurance payment will be sent to the insured. When you receive the payment from a secondary insurance, please mail us an Explanation of Benefits along with your personal payment by check, money order, or credit card. Please do not mail us an insurance check that was written to your name because our bank does not accept third party checks.

If a patient does not have a secondary insurance, the 20% coinsurance not paid by Medicare will be patient's financial responsibility. In such situation, it is the office policy to have a method of payment such as a credit card on file. With your permission, we will use this information to process payment. Please note that we will charge the credit card provided below to pay for any outstanding balances on the account. We will do that once the insurance company notifies us the claim has been finalized and the payment was sent to the insured. One of our representatives will contact you prior to charging the credit card. To the extent any sums due and owing are not obtained at the 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.

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 Medicare financial policy terms and conditions.

Patient Name: _____ Date: ____/_____/_____

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

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