

It is the policy of this office that, in cases where applicable, fees will be filed with patient's insurance company, provided the correct insurance information is on file. After payment is received, the balance will be billed to the patient. Fees for cosmetic procedures are collected prior to surgery. Deposits may be required for elective and non-emergency surgery.

I understand that my medical insurance is a contractual agreement between me and my insurance company, with the company to pay a specified amount for medical care. The fees of this office are not based on the amount insurance will pay. The amount approved by my insurance company for payment on a particular procedure may be more or less than the fee charged. I understand that full payment for my treatment remains my exclusive financial responsibility, including charges not covered by my insurance carrier. If I am unable to meet this obligation, I will contact the Accounts Manager immediately to arrange a payment schedule.

I understand and agree to all statements contained herein and further understand that failure to comply with this agreement may subject me to collection activity at my expense.

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DATE

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Signature of Patient or Guarantor (if minor)

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the release of medical information to my specified insurance carriers or individuals having just cause to request such information. I authorize direct payment of surgical and medical benefits to Salem Plastic Surgery.

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DATE

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Signature of Patient or Guarantor (if minor)