Aesthetic Arts Institute of Plastic Surgery
Dr. Susan Kaweski
8415 Grant Avenue La Mesa, CA 91941

FINANCIAL/PAYMENT POLICY

Thank you for choosing Aesthetic Arts Institute of Plastic Surgery. We are committed to providing you with quality and affordable health care. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we developed this financial/payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. INSURANCE
We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility; please contact your insurance company with any questions you may have regarding your coverage.
Proof of Insurance All patients must present a current valid insurance card before seeing the doctor. If you fail to provide us with your correct insurance information in a timely manner, you may be responsible for the balance of a bill. When your insurance changes, please notify us before your next visit so we can make the appropriate changes and help you receive your maximum benefits.
Claims Submission We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly; it is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
Non-Covered Services Please be aware that some-and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurance plans. You must pay for these services in full at the time of your visit or as soon as we notify you that the services will not be covered by your insurance plan.

2. CO-PAYS
All co-pays must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays from patients can be considered fraud. Please help us in upholding the law by paying your co-pays at each visit. A billing fee may be added to the amount due if a statement must be sent to you for an unpaid co-pay. If you have two insurances, your primary insurance co-pay is applicable; co-pays are not billable to any secondary/supplemental insurance plans.

3. NON-PAYMENT OF ACCOUNT
Please be aware that if a balance remains unpaid over 90 days, we may place your account in pre-collection status or refer your account to a collection agency. These actions can possibly jeopardize any future appointments or result in discharge from this practice.

4. MISSED APPOINTMENTS
Our policy is to charge $50.00 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointments.

Thank you for understanding our financial/payment policy. Please let us know if you have any questions or concerns.

I have read and understand the financial/payment policy and agree to abide by its guidelines:

______________________________ ______________

Signature of Patient or Responsible Party Date

Notice of Privacy Practices and Assignment of Benefits

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this "notice", sign and return this form along with your other paperwork to our office.

We collect, use, and disclose information provided by and about you for healthcare payment and operation, or when we are otherwise permitted or required by law to do so. We must have your written consent to use and disclose health information for the following purposes:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, or other personnel who are involved in taking care of you and your health. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling procedures, and ordering X-rays. Other health care providers may be part of your medical care outside of this office and may require information about you that we have.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party.

For Health care Operations: We may use and disclose health information about you in order to run this office and make sure that you and our other patients receive quality care.

Appointment Reminders: We may contact you or your representative as a reminder that you have an appointment for treatment or medical care at this office.

As Permitted or Required by Law: Information about you may be used or disclosed to regulatory agencies, such as during audits, licensure or other proceedings; for administrative or judicial proceedings; to public health authorities; or to law enforcement officials, such as to comply with court orders or subpoena.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability or report suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Family/Friends: We may disclose health information about you to your family or friends if we obtain your verbal or written agreement to do so. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family or friends is in your best interest. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person or persons to act on your behalf in scheduling office appointments, procedures or other necessary services to coordinate your care.

Other Uses and Disclosures of Health Information: Other uses and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. We will then stop using your information for that purpose. However, if we have already used your information based on your authorization, you cannot take back your agreement for those past situations.

Right to Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request in order to inspect and/or copy your health information. Our office will provide copies of your records for a reasonable fee.

Right to Amend: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, complete and submit a Medical Record Amendment/Corrections Form to this office. We may deny your request for an amendment that is not in writing or does not include a reason to support the request.

Right to an Account of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. You must submit your request in writing to this office. It must state a time period, which may not be longer than six years.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. To request restrictions, you may complete and submit the Request for Restrictions on Use/Disclosure of Medical Information to this office.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communications to this office.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services.

ASSIGNMENT OF BENEFITS-FINANCIAL AGREEMENT

I hereby give authorization of insurance benefits to be made directly to Susan Kaweski, M.D., FACS for services rendered. I understand that I am financially responsible for all charges

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Signature of Patient or Responsible Party　　　　　　Date