Financial Policies

Fante Eye and Face Centre

4500 Cherry Creek Drive South, Suite 550
Denver, Colorado 80246

Payment is expected at the time of service for all non-contracted fees. Arrangements must be made prior to seeing the physician if an account balance is anticipated. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Private Insurance

All private health insurance plans represent a contract between you and the insurance company. These contracts are not between the physician and the insurance company. As a courtesy, we will bill your insurance for all services rendered, but we are not responsible if your insurance does not pay. Instead, it is your responsibility to make certain that your insurance makes prompt payment, and to handle any disputes or questions that may arise.

_____ (initial) If I have not yet met my deductible, I agree that there is a $500 deposit due upon scheduling surgery

_____ (initial) If I cancel a medical surgery within one month of the scheduled date, I will owe a $500 cancellation fee. Insurance will not cover this fee.

Insurance Contracts

If we participate with your insurance carrier, we will accept assignment on all covered services and bill your insurance for you. You are responsible for the copay, deductible, and all non-covered services. Depending upon your particular benefits package with your insurance, they may cover some, all, or none of the services rendered to you. Therefore it is your responsibility to:

1. Provide documentation of your coverage
2. Know what benefits are covered by your insurance and what services are your personal responsibilities.
3. Provide the appropriate documents (e.g. referrals) that allow us to bill your insurance carrier. If the appropriate information is not received, you will be asked to sign a waiver of responsibility.

Medicare

We accept Medicare assignment, which means that we accept the allowable charges set by Medicare. Medicare typically pays 80% of the allowable charge after your deductible has been met. You will be responsible for the 20% remainder unless you have a Medicare supplement or replacement plan. We will bill your Medicare supplement after Medicare has paid, if you provide the necessary information to us.

Surgery Center Requirements

If a surgery is planned at a surgery center, I understand and accept the responsibility to have preoperative clearance, labs, and EKG performed by my PCP, according to the requirements of the surgery center.

Cosmetic Revisions

Rarely, after complete healing from surgery for which insurance has paid, you and your surgeon may agree that some revision procedure would enhance your cosmetic outcome. I understand that aesthetic surgery is not a covered benefit of Medicare and other insurance carriers. Therefore any aesthetic procedure will be my financial responsibility and payment in full will be expected prior to the procedure.

Medical Authorization Release

- By signing below, I authorize Fante Eye and Face Centre to give me reasonable and proper medical care by today's standard.
- I agree that the attending physician may use, or permit other persons to use any negatives, prints, movies, and digital images, and/or other visual or audio recordings, for purposes including, but not limited to, dissemination to health care professionals and/or members of the public for treatment, research, medical or scientific teaching, or other purposes in such a manner as may be deemed appropriate by my attending physician. I agree that this information may be used in either paper form or digital form.
- I hereby authorize Fante Eye and Face Centre to release any medical or other necessary information to insurance carriers in either paper or digital from concerning this illness/accident. I hereby irrevocably assign all payments for all services rendered to Fante Eye and Face Centre. I also request payment of government benefits either to myself or to Fante Eye and Face Centre. I have read and understand the policies described above. I have provided complete and accurate medical and financial information on all forms. I acknowledge that I am responsible to pay all charges for treatment as outlined above.

A copy of this authorization shall be considered valid as the original.

_____

Patient Signature Date

_____

Responsible Party Signature (if not patient)

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