Maxillofacial and Facial Aesthetic Surgery, Ltd.
Kevin R. Haddle MD

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Our notice of privacy practices provides information about how we use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. By signing this form, you acknowledge that you have received a copy of, read, and understand our Notice. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the rights to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has Notice of Privacy Practices and that the patient has reviewed this notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their Information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The patient may condition treatment upon the execution of this Consent.

Signature____________________________________

Relationship to patient (if other than patient):_________________________

Date___________________

BENEFIT AUTHORIZATION
I authorize payment of medical benefits to the undersigned physician or supplier for services described here.

RELEASE OF INFORMATION
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature____

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Thank you for selecting us as your health care provider. We are committed to your successful treatment. The following is a statement of our Financial Policy. Please read all sections of the policy. If you have any questions or concerns, contact our business office at (630) 232-9090. We require this notification to be completed annually prior to the provision of any services.

UNLESS YOU ARE A MEMBER OF ONE OF OUR CONTRACTED PLANS, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

CONTRACTED PLANS
Even if Maxillofacial and Facial Aesthetic Surgery, Ltd. is contracted with your health plan, the majority of members are still required to make some type of payment for service(s) rendered. This patient liability may be in the form of a co-payment, deductible, and/or co-insurance. Co-payments, deductibles, and co-insurance are requirements of your insurance plan not Maxillofacial and Facial Aesthetic Surgery, Ltd. We are required under our contract with these plans to collect these amounts from you.

HMO PLANS
Most of these plans require that you obtain a referral from your primary care physician prior to receiving any services in our office. If you do not obtain a referral from your primary care physician prior to receiving services, or a referral can not be verified by our business office, you have the option of rescheduling your appointment. If you keep your appointment and/or receive services in our office it is with the understanding that your health plan may not pay for charges related to the services provided by Maxillofacial and Facial Aesthetic Surgery, Ltd. and that without a referral you will be responsible for payment of all charges.

SELF PAY/NON-CONTRACTED PLANS
Payment is due at the time of service unless prior financial arrangements have been made with our business office. All previous balances are expected to be paid in full prior to new services being rendered.

DIVORCE SITUATIONS
We look to the adult who has brought the child in for the appointment to be responsible for payment of the services which are rendered to the child. We expect the parents to be able to work out payment arrangement with one another. Our office staff will not participate in any disputes which may arise with respect to financial liability or responsibility.

MEDICARE
We do not participate with Medicare, therefore, you will be responsible for the balance in full.

________ *(INITIAL)* **THE ESTIMATES WE PROVIDE FOR YOU IS NOT A GUARANTEE OF BENEFITS AS QUOTED BY YOUR INSURANCE COMPANY. Maxillofacial and Facial Aesthetic Surgery, LTD. is not responsible for any misquoted benefits.**

YOU WILL RECEIVE AN ITEMIZED STATEMENT FOR YOUR SERVICES IN THE MAIL AFTER YOUR PROCEDURE. IF YOU DO NOT RECEIVE IT IN 2 BUSINESS DAYS, PLEASE CALL US.

IF YOUR INSURANCE DOES NOT PAY ON THE CLAIM WITHIN 45 DAYS, THEN YOU WILL BE BILLED FOR THE TOTAL AMOUNT REMAINING. YOU WILL BE GRANTED AN ADDITIONAL 15 DAYS TO MAKE PAYMENT. IF PAYMENT IS NOT SUBMITTED BY THE 16TH DAY, YOU WILL BE SENT TO KCA COLLECTIONS AGENCY WITH A 33% COLLECTION FEE.

I have read the above Maxillofacial and Facial Aesthetic Surgery, Ltd. Financial Policy Notification and understand my financial responsibility with Maxillofacial and Facial Aesthetic Surgery, Ltd. I hereby affix my signature as an acknowledgement of this understanding.

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Print Patient Name

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Patient/Responsible Party Signature

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Date