ELSA RASKIN, M.D.
PLASTIC & COSMETIC SURGERY

Billing and Payments

Insurance covered office visits and procedures (if applicable)

I allow the office staff of Dr. Elsa Raskin to bill my insurance provider and to act on my behalf when discussing all medical claims and payments regardless of if her office is participating or not with my insurance provider.

□ ***For insurance patients:***
I understand that it is my responsibility to know my insurance plan. I understand and agree that I am financially responsible for any co-pays, co-insurances, or deductibles as stated by my insurance company. Furthermore, if my insurance is not accepted by the doctor, I understand and agree that I may be billed for the remainder of money owed for any services rendered.

***I understand that if my account balance is not paid within 60 days, a 15% interest charge will be applied.**

Cosmetic and non-covered consultations and procedures (if applicable)

The patient is financially responsible for all cosmetic and non-covered Consultation and procedures.

This office does not bill insurance companies for cosmetic and non-covered consultation and procedures.

I, the undersign patient, state that I have requested a cosmetic or non-covered consultation and /or procedure with: ELSA RASKIN, M.D.

I, the undersigned patient agree to the following:

I AM FINANCIALLY RESPONSIBLE FOR THE FULL COST OF THE CONSULTATION AND OR PROCEDURE AT THE TIME OF SERVICE ARE RENDERED.

General Policies

***PAYMENT MAY BE MADE BY CASH, CHECK, MASTERCARD, VISA, AND AMERICAN EXPRESS CARD.**

***If in any case an insurance company and/or credit card company requires the release of medical treatment to verify charges I agree to my records being released especially in the event that there is a dispute of charges.**

□ I agree with the above

Patient Signature _____ ***date*** _____