Yee Plastic Surgery, PLLC
Financial Agreement

This agreement made and entered into is to be effective as of the date recorded below between Yee Plastic Surgery, PLLC, herein referred to as YPS, and patient, or Responsible Party if not the patient, herein referred to as patient, and named below. By executing this agreement, patient agrees to pay for all services provided by YPS.

Payments: Payment must be received in full at the time of service. We accept cash, cashier's check, personal check (except for cosmetic surgeries), Visa, MasterCard, American Express, and Discover. YPS accepts payment plans only through CareCredit for transactions over $200.

Insurance: Patient is responsible for providing correct demographics and insurance information **prior to appointment**. Otherwise, patient will be considered self-pay without insurance. We **do not** retroactive pay or re-submit claims to insurance after service is rendered or once patient is scheduled as self-pay. Patient will be required to pay any co-payments, co-insurances, and/or deductibles not met at time of service. ***Any rendered services not covered and/or denied claims by insurance will become patient's responsibility.***

Statement: Patient will receive statement in the mail once balance is due. Any balances not paid in full after third statement will be sent to our third party collections agency. ***Any rendered services not covered and/or denied claims by insurance will become patient's responsibility.***

In Office Surgery Cancellation/No Show Policy: ***$50 fee*** will be charged if patient does not cancel or reschedule ***at least 24 hours in advance from scheduled date and time***. Fee will automatically apply for no show appointment.

Surgeries filed through Insurance: For outpatient surgery, patient will pay full amount for physician's charge(s) at pre-op appointment, and in office surgery at the time of service (deductible, co-insurance, and/or co-payment). If insurance terminates or changes during and/or after services are rendered, patient is responsible for full payment to YPS. If surgery is performed outside our office, expect charges from other entities such as surgery center, hospital, pathology, and anesthesiology. For in office procedure, expect separate charges from pathology or labs. YPS is only responsible for verifying benefits for physician charge(s). ***Any rendered services not covered and/or denied claims by insurance will become patient's responsibility.***

Cosmetic Services: Patient is responsible for all cosmetic charges at the time payment is collected. ***$50 non-refundable cosmetic consultation fee*** will be collected at the time appointment is made. If patient decides to do surgery with Dr. Yee, $50 fee will apply towards Dr. Yee's charge. At time surgery is scheduled, YPS will collect ***$250 non-refundable surgery deposit fee*** and the remaining balance will be collected at pre-op appointment. If patient cancels surgery and does not reschedule, ***there will be an additional 3% transaction fee only if payment was made by debit/credit card***. YPS is not responsible for anesthesia and surgery center charges and billing processes.

NSF Checks: Patient will be charged $30 insufficient funds fee in addition to the amount of the check for any returned check. Thereafter, YPS will only accept cash or debit/credit card.

Medical Records/Employer Paperwork: Patient will not be charged a fee for medical records sent through patient portal. Fee may apply for printed copies of patient's medical records. Patient must fill out HIPAA Medical Release Form for every medical records request. Fee may apply for FMLA or any paperwork requested by patient's employer.

By signing this agreement, Patient agrees to all of the terms and conditions contained herein and the agreement will be in full force and effect. I authorize the use of my signature on all insurance submissions. YPS may use my health care information and may disclose such information to my insurance carrier and their agents for the purpose of obtaining payment for services determining benefits payable for related services.

Printed Patient's Name: _____ Date of Birth: _____
(if applicable) Patient's Legal Guardian: _____ Relation to Patient: _____

Signature (Patient or Legal Guardian) _____ Date _____