Harris Plastic Surgery
500 Montauk Highway
Suite H
West Islip, NY 11795

## INSURANCE PAYMENT POLICY – OUT OF NETWORK DISCLOSURE

I, ________________________________________, understand that **Dr. Stephen Harris is NOT participating with my insurance company**; therefore, any medical service will be processed toward my *out-of-network benefits*.

I understand that Dr. Stephen Harris has agreed to accept the "AMOUNT ALLOWED" by my insurance company, which, in most cases, represents a discount of his customary fee.*

I undertand the "ALLOWED AMOUNT" is the dollar value *my insurance company dictates* as the usual and customary amount for the service performed. I understand the "PAYMENT AMOUNT" is the dollar value actually paid by *my insurance company.* I understand that any "PAYMENT AMOUNT" paid by *my insurance company* may not satisfy the "ALLOWED AMOUNT", and **I, therefore, agree to pay any balance due up to the "ALLOWED AMOUNT"**. This difference between the "ALLOWED AMOUNT" and the "PAYMENT AMOUNT" is made up of the amount applied to the *deductible and coinsurance*.

I understand that I may receive payment and/or correspondence from my insurance company and agree to remit any payment and/or correspondence to Dr. Harris immediately upon receipt.

I understand that I will receive a bill from Practice Management Advisors, the billing service for Harris Plastic Surgery, reflecting any outstanding unpaid balances.

*I UNDERSTAND AND AGREE: HARRIS PLASTIC SURGERY IS AWARE WHEN I RECEIVE A CHECK FROM MY INSURANCE COMPANY AND IT IS MY RESPONSIBILITY TO FORWARD THE INSURANCE CHECK AND EOB TO THEIR OFFICE. IF THIS CHECK IS NOT RECEIVED BY HARRIS PLASTIC SURGERY WITHIN 14 DAYS OF RECEIPT, THE ABOVE COURTESY WILL BE VOIDED AND I WILL BE RESPONSIBLE FOR THE ENTIRE BILLED AMOUNT FOR SERVICES RENDERED.

Please feel free to discuss this policy with Joanne Parrinello or Dr. Harris in order that we may assist you in this matter. *By signing this form, I fully understand and agree with above stated office policy.*

______________________________________________ ____________________

Patient Signature Date