



**LOWE PLASTIC SURGERY (LPS)**  
**AUTHORIZATION FOR MEDICAL TREATMENT AND**  
**FINANCIAL RESPONSIBILITY**

**1. CONSENT**

**I authorize my physician and other physicians who may attend me, their assistants, including those employed by Lowe Plastic Surgery (LPS) or Associates Surgery Center (ASCO), to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my physician.** These services may include emergency services and other special services ordered by my physician(s). In consenting to treatment, I have not relied on any statements as to results. I further authorize my physician or associated staff to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any bones, organs, tissue, fluids or parts removed from my body.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis B & C, and HIV. **I also agree to update this office of any related information and health history that may change over the course of my care.**

**2. STORAGE AND RELEASE OF INFORMATION**

**I consent to the electronic storage and transmission of patient health information.** I hereby authorize my treating physician, or LPS or ASCO, to release by electronic means or otherwise any medical and/or billing information that concerns my care, including copies of my medical records, to the following:

- Any governmental or other entity as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
- The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring.
- Any continuing care, residential or long-term care facility, or home health agency for the purposes of providing services for my care.

**3. MEDICARE / OTHER INSURANCE BENEFITS**

**I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct.** I authorize the release of medical or other information to the Medicare Program or its Intermediaries or carriers concerning this or a related claim filed by LPS. I request payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges.

I (or my representative) certify that I (or he/she) have read (or if the patient/representative is unable to read has had the form read to him/her) and understand, accepts the above and further certify that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

#### 4. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by LPS, all physicians and services, I authorize direct payment to LPS and/or the associated facilities of all insurance benefits applicable to these medical and other services, which are now or which shall become due and payable. In addition, I hereby authorize payment to LPS of applicable insurance benefits for medical and/or surgical services rendered by physicians or representatives for whom the entity is authorized to bill and collect.

**I understand that LPS may utilize facilities or other services in or out of my insurance network. Fees or other concerns associated with such interactions should be addressed with that entity directly.** Certain ancillary services (i.e. lab work or pathology) or facilities that are routinely outsourced by the practice may not be partially or fully covered by my insurance. LPS can never guarantee that other consultants or services will be covered by my insurance plan. I understand that I should contact my insurance for further information. I also understand that if my insurance plan has specific restrictions on such services, I need to make a written request in advance of care for special accommodations. In some cases, based on the restrictions of the insurance plan, accommodations cannot be made and an out of pocket cost may be incurred if care is to be provided. LPS may on occasion utilize facilities or services in which it has direct interest or ownership.

**Patients who request evaluation for a medical condition through insurance will be billed based on a standard fee schedule.** It is noteworthy that the actual fee paid is often significantly reduced due to contractual agreements. Those conditions deemed medically indicated, which are generally covered by insurance, will be billed based on a pre-determined fee schedule. **Cosmetic consultation fees and other associated discounts are only applicable for visits for cosmetic conditions.** LPS reserves the right at any time to cancel, not renew, or re-negotiate any health plan based on contract terms.

#### 5. GUARANTEE FOR PAYMENT

**In accordance with the above terms and in consideration of the services provided to the patient by LPS, the undersigned agrees, whether he/she signs as patient or guarantor, to pay LPS and related facilities for all services ordered by the physician, or requested by the patient and/or the patient's family.** If the requirements for referral, second opinion, pre-certification of care, hospitalization, or surgery as otherwise outlined by the insurer, benefit plan or other payer, have not been fully followed, the patient /or guarantor agrees to be personally responsible for all charges incurred. LPS intends to provide timely invoices, but due to the complexities of medical billing, delays may occur. Please contact LPS or the billing company if there is concern about the invoice. Patients may request, or may be required, to file their own insurance claims. If the patient /or guarantor fails to pay within a timely manner or payment is invalid or insufficient, then extra charges will be incurred, and a collection agency will be utilized.

As in any office, the physician may not be on time due to paperwork, unexpected issues, or an emergency. The physicians do their best to provide timely care, and to stay on schedule, but medicine can be unpredictable and delays do occur. Patients can help by respecting the physician's time by focusing on the reason for their visit. Physicians may not be able to provide an expected service, or provide the desired service, on an anticipated day. Patients who speak a language other than English must provide their own translator. Patients should be aware that fees are related to the time and complexity of their visit or procedure. **Note that failure to provide 48 hours notice when cancelling an appointment will result in a minimum \$30 cancellation fee.**

## 6. ADVANCE BENEFICIARY NOTICE (ABN)

Patients and families must make choices in their care as it relates to clinical services and insurance coverage. Insurance is a means to assist in payment of medical services. Insurance companies are not health care providers. The fact that a patient's medical insurance does not pay for services provided, recommended, or arranged does not mean that the patient should not receive said services or that such are not indicated. Physicians recommend treatments, medications, and services based on their experience, knowledge and training in the practice of medicine.

No matter what the situation or process, your insurance provider may choose not to pay for your medications, treatments, or services. Not all medically indicated services will be covered by your insurance, regardless of the timing, notification, or approvals. This does not mean that the procedure of service was not "coded correctly" by the physician. Many health insurances simply make a blanket statement that they will pay for a service if it is "medically indicated." Only later will the insurance company review the records and decide independently how much they will cover, if at all. This is part of most patient insurance contracts and is not negotiable. For instance, Medicare will not guarantee payment of any service in advance.

Insurance companies may not be forthright with their rules and regulations and may not notify physicians regarding policy changes. Concerned patients should review their individual health plan and contact their insurance providers regarding fees or coverage. If you do contact your insurance provider, you should document the number you called, the date and time of your call, who you spoke with, and get a reference number for your records.

Please remember that we are here to take care of you. Our staff spends an extensive amount of time working with insurance companies to assist in prior authorizations for medications, pre-determinations for surgery, sending records to verify that your services were "medically indicated," etc. We do our best to assist you with this complicated and exhaustive process and our intention is to be honest and transparent. By signing this document you understand that your medical insurance may not cover part or all the services provided, recommended, or arranged and that you will be responsible for the bill.

Please also note that you have a contract with your insurance company and, if we are in your network, then we have a contract with your insurance policy. We, or any other physician or provider, cannot "waive" your co-pay or deductible. Doing so would be a violation of your contract and our contract with the insurance provider. In the same way, as part of our contract, your insurance sets the fee schedule that determines the amount that we are paid for your services. We cannot lower or adjust that amount, and we cannot see you and not charge you as that also would violate our contractual agreement with the insurance company.

## 7. FINANCIAL POLICY

You are responsible for payment of all medical treatment and related services provided by LPS. As a service and out of consideration to you, this office will, in most cases, file insurance claims for covered services. As appropriate, based on our contractual provisions with your insurer, this office will accept your insurance's maximum allowable reimbursement. **You are responsible for any deductibles or co-payments and any non-covered services (i.e. medical supplies, clerical work, etc.) incurred.** You agree to pay these fees regardless of your interpretation of information provided from LPS staff or physicians, and you agree to be responsible for interpreting the complexity of your own health plan.

- All accounts are considered due after payment from insurance company is received.
- For your convenience, we have secured arrangements for partial payments

- **The following include but are not limited to TWO OPTIONS made available under the financial policy as it pertains to an outstanding balance.**

**Option 1:** Pay the account in full. Enclose payment for the complete balance.

**Option 2:** In the event that we do not receive payment in full within 30 days from the statement date, the following will automatically occur:

- 1) Gemini Financial Services, LLC (GFS), shall be the agent on this account for future billings.
- 2) The patient shall be billed \$15.00 annual fee by GFS for account set up & administrative costs.
- 3) The patient shall be billed 1.375% monthly service fee on the outstanding balance.
- 4) The patient will be required to pay the GREATER of \$25.00 or 3% of the outstanding balance each month until the balance is paid in full.
- 5) The Attorney General of Oklahoma will be notified regarding any false payments, bounced checks, or payment fraud if the problem is not resolved in a timely manner.

**8. INDEPENDENT PRACTICES & AGREEMENT TO HOLD PARTIES HARMLESS**

I understand that Jim Lowe MD, and any other on-site doctor practice independently of one another. I agree that if I am a patient or under the care of any one of the doctors or their representatives, or their physician assistant or aesthetician, I hold the other doctors harmless for any events while under one doctor’s or their representative’s care. Independent physicians have no financial ties to LPS of Oklahoma or its related companies. I understand that all other physicians “practices” function as independent corporations or entities. If I am a patient of Jim Lowe MD, or another MD, I hold all other doctors harmless for any events under their care. Likewise, if I am a patient of any other physician practicing on-site, I hold Jim Lowe MD, and Lowe Plastic Surgery, or any related corporations, harmless for any events while under their care. Likewise, if I am a patient of Associates Surgery Center, I hold any other MD, Lowe Plastic Surgery, or any related corporations or uninvolved doctor or staff harmless for any events while under their care.

**9. RELEASE OF INFORMATION TO FAMILY AND FRIENDS**

I authorize the following person(s) (or class of persons) to receive my protected health information: \_\_\_\_\_

**HIPAA-Notice of Privacy Practices Acknowledgement**

**I acknowledge I have been given the opportunity to receive a copy for review only of the “Notice of Privacy Practice” that explains when, where, and why my confidential health information may be used or shared, I acknowledge LPS, the physicians, physician assistants, and other staff may use and share my confidential health information with others to treat me, and to arrange for payment of my bill & for issues that concern LPS operations and responsibilities.**

\_\_\_\_\_  
Signature of patient or person                      Date

\_\_\_\_\_  
Patient’s relationship to person

\_\_\_\_\_  
Signature of Guarantor                              Date

\_\_\_\_\_  
Patient’s Relationship to Guarantor

\_\_\_\_\_  
Signature of Witness                                Date