THOMAS TREY SANDS, M.D.
4224 Houma Boulevard Suite 120
Metairie, Louisiana 70005

OFFICE POLICY REGARDING PERSONAL HEALTH INSURANCE AND FINANCIAL POLICY

(Please read and Sign)

Aesthetic (Cosmetic) Surgery

These procedures are not covered by Insurance; therefore they must be prepaid in full two weeks prior to surgery. A $300.00 non-refundable deposit is required to reserve your surgery date.

Personal Health Insurance

Patients who have medical or surgical insurance whether it is an indemnity, PPO, POS, HMO, Managed Care plan or supplemental health insurance will be fully responsible for the **total fee** of any cosmetic procedure quoted to you by the patient coordinator. We will make every attempt to **pre authorize** any non cosmetic surgery, and we will find out if your surgery is a covered procedure under your plan. We will also **pre certify** your hospital admission or out-patient procedure. Pre-certification means that your insurance company allows your admission as a medical necessity but does not mean they will pay for your surgery. **Pre certification and pre-authorization are not a guarantee of payment. You are responsible for the total fee quoted to you, if your insurance denies coverage after the procedure is performed. Please remember your insurance contract is between the patient and the insurance carrier, not with the physician. If your surgical procedure is being pre certified and you choose to schedule your surgery prior to having the authorization; we will not file with your insurance afterwards, even if the surgery is approved.**

Your insurance company may have a standard fee that will pay for any specific surgical procedure. This **usual and customary** fee is a fee that is generated by your insurance company. This is what they are willing to pay for that specific surgical procedure. You are responsible for the fee quoted by our patient coordinator. You need to cooperate with our office staff to expedite the precertification and pre authorization process as well as take active participation in the payment of your bill by your insurance carrier. Any appeals before or after surgery are your responsibility, but we will assist you with the information and the paperwork necessary.

I have read and understand this policy and will fully cooperate with the office staff.

Patient's Signature_________________________ Witness__________________________

Date: _______________