



THE NEW YORK
AESTHETIC CONSULTANTS, LLP
PLASTIC, LASER & DERMASURGERY

DERMASURGERY
RON M. SHELTON, M.D., F.A.A.D.

NEW YORK OFFICE-BASED SURGERY, PLLC



Accredited by The Joint Commission

PLASTIC SURGERY
TED CHAGLIASSIAN, M.D., F.A.C.S.
WILFRED BROWN, M.D., F.A.C.S.

MEDICARE FINANCIAL POLICY

Welcome and thank you for selecting the New York Aesthetic Consultants. We wish to provide you with the best possible administrative, medical and surgical care. It is our desire to be as attentive as possible to your financial needs.

ALL MEDICARE BENEFICIARIES are required to pay the annual deductible. After the deductible is met, Medicare will pay 80% of their **allowed** amount. Under Federal law, we must bill the patient the 20% remaining balance. This is called "co-insurance". If you have a secondary, Medicare supplemental insurance policy, this 20% is usually covered by them. As a courtesy we will file a claim to them, but payment is expected within 30 days. If they do not pay your claim, or if the claim is underpaid, this balance is your responsibility.

If **Oxford** or **United Healthcare-Empire Plan** is your secondary insurance company, the reimbursement for the coinsurance will be sent to you. When you receive the payment from them, please send your personal payment (check, money order, credit card). Please do not forward your insurance check to us since our bank does not accept a third party check.

If you do not have a secondary insurance, the 20% coinsurance not paid by Medicare will be your financial responsibility. In such situation, it is the office policy to have a method of payment such as a credit card on file. With your permission, we will use this information to process payment. Please note that we will charge the credit card provided below to pay for any outstanding balances on your account. We will do that once your insurance company notifies us the claim has been finalized and the payment was sent to you. One of our representatives will contact you prior to charging the credit card. If you have questions regarding this policy, please ask to speak to a billing representative.

<p>Mastercard _____ Visa _____ American Express _____ Discover _____</p> <p>Card # _____</p> <p>Exp _____ / _____ Security ID # (3-4 digits, on back of card) _____</p> <p>Card Holder _____</p> <p>I hereby authorize The NYAC to charge my credit card and hereby confirm I will not dispute this charge with my credit card company. Signature _____</p>
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By signing below, I acknowledge I have read and agree to the above Medicare financial policy terms and conditions.

Patient Name: _____

Patient/Legal Guardian Signature: _____ Date: ____/____/____