# Revalla Plastic Surgery


## Lisa M. Hunsicker, MD, FACS

7750 S. Broadway, # 150 • Littleton, CO 80122-2634

Phone (720) 283-2500 • Fax (720) 283-1122


**Patient Name** _____ **Date** _____
Last Name First Name Initial

## INFORMED INSURANCE CONSENT

**Person Responsible for Account** _____
Last Name First Name Initial

Relationship to Patient _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Bus. Phone _____

SS# _____ Employer _____

Insurance Company (Primary) _____ I.D.#_____

Group# _____ Provider/Customer Service Phone # _____

Insurance Company (Secondary) _____ I.D.#_____

Group# _____ Provider/Customer Service Phone # _____

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I have chosen to receive specialty care from Lisa M. Hunsicker, MD and Revalla Plastic Surgery (hereafter referred to as the practice). As such, **I agree to accept full financial responsibility** for any direct or ancillary charges related to the care I receive from the practice**. I agree to pay all deductibles, co-pays and applicable co-insurance** (if I have dual coverage, my co-pay, deductible and co-insurance will be based on the primary coverage). All co-pays are due on the date of service. If a pre-authorization/certification or referral is required by insurance to receive insurance benefits I understand this is **not** a guarantee of payment by my insurance company. I understand that I am responsible for ensuring referrals have been obtained prior to office visits and procedures.

As a courtesy to our patients, we will file your insurance forms for you. Your insurance is an agreement between you and your insurance company. As a medical provider, we bill your insurance company for all your office visits and your surgery (excluding nicotine & recreational drug testing). Generally, this includes your initial consult, pre-op and any follow-up visits that occur 90 days after your date of surgery. (The follow-up appointments within 90 days after surgery are considered part of the "global period," and are included as part of your surgical billing.) You are responsible for any and all charges that are not paid by your insurance carrier, and your financial obligation to this office for payment is not dependent on the insurance coverage. Any balance not paid after 45 days is your responsibility, **regardless of any insurance payments that may yet be received by this office.** A service charge may be applied to overdue accounts. Once insurance benefits are received, we will reimburse you for any overpayment or send you a statement for any remaining balance.

The practice is in-network with the following insurance companies:

- Anthem, Blue Cross/Blue Shield
- United Health Plan
- Humana
- Aetna

**AS OF APRIL 2, 2018, THE PRACTICE IS NO LONGER CONTRACTED WITH MEDICARE (INCLUDING MEDICARE ADVANTAGE PLANS). YOU CANNOT FILE ANY CLAIMS TO MEDICARE SINCE WE ARE NO LONGER PROVIDERS. SHOULD YOU CHOOSE TO CONTINUE YOUR CARE WITH DR. HUNSICKER WE WILL OFFER YOU THE $50.00 SELF PAY RATE DUE AT THE TIME OF SERVICE.**

If we are out of network with your insurance, we will check your out of network benefits and discuss your options with you. If your insurance company denies authorization for your surgery, you may reschedule your surgery and appeal or choose to move forward with the surgery at your out of network benefit level. **Ultimately you accept full responsibility for payment of charges for all services,**

Your insurance company sends EOB's (Explanation of Benefits) to our office as well as to you. EOB's show how a claim was paid, how much was paid to the practice by your insurance company and what amount is owed to the practice (if anything).It is important for you to check your EOB's for accuracy and notify both your insurance company and the practice of any errors.

If at any time you have questions regarding your health insurance, authorizations or statements you may contact our office 720.283.2500 or our billing company Kareo at 1-888-775-2736.

_____ Date _____

**Signature of Patient**

_____Date _____

**Signature of Person Responsible for Payment**