

Texas Center for Breast Reconstruction

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Financial Policy

Patient Payments

Payment is expected at the time services are rendered. If you do not have insurance, we can provide an estimate as to how much your visits and care will cost. Co-payments are due at the time of your office visit. You may be asked to pay any remaining deductibles or account balance prior to surgery. Our office accepts cash, checks, Visa, Mastercard and American Express. If you are experiencing a financial hardship or are unable to pay your balance in full, please let us know. In most cases we are able to make payment arrangements.

Cosmetic

Cosmetic surgery and cosmetic procedures are not covered by health insurance. All cosmetic services must be paid for in advance by the patient (cash or credit card, no checks for cosmetic surgeries/procedures). After undergoing a consultation, a quote will be generated that lists out the various estimated costs of the cosmetic surgery. In order to schedule a surgery date, we collect a non-refundable booking fee. The amount of the booking fee is 25% of the surgeon fees, with a \$200.00 minimum. The balance of all surgical fees must be paid in full prior to surgery. The booking fee will hold your surgery date and it is non-refundable. Payment for cosmetic surgery can be made in the form of credit card and cash.

Insurance

Your insurance policy is a contract between you and your insurance company. We are contracted and in-network with most insurance companies, however it is your responsibility to check with your insurance company to verify network participation with providers and facilities. It is your responsibility to understand the policy type, limits, benefits, coverage and what your out-of-pocket costs are. If your insurance requires a referral from a PCP, you are responsible for making sure our office is in receipt of a referral. Insurances only cover procedures which the insurance company determines to be medically necessary. No insurance company will guarantee coverage prior to a surgery. Our office verifies your eligibility and benefits. We may submit a pre-determination letter to your insurance company to see if they consider a procedure medically necessary and will also obtain pre-certification or prior authorization when applicable. We will bill your insurance company directly on your behalf. You will be sent a statement for the remaining portion that is deemed your responsibility as per your insurance company. If the insurance determines the services rendered were not medically necessary, you will be financially responsible.

In and out of network-Consumer notice

We are in network with most insurance plans. You must check with your insurance company to ensure network participation when you seek care. Patient consent is required to receive care on an out of network basis at higher out of network rates. By signing below, you acknowledge that you are providing consent for treatment and higher out of network rates if we are not in network with your insurance plan.

Patient agreement

We ask that you sign below to indicate you have read and understand the above policy. Your signature also indicates that you agree to cooperate with any requests from your insurance company in a timely fashion, and to notify us of any insurance changes in a timely fashion. You also acknowledge and agree that you are financially responsible for all services rendered including cosmetic procedures, denied claims, copayments, deposits, and deductibles. If you have any questions regarding the above policy, please do not hesitate to ask at any time

Signature

Printed Name

Date