

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**M. Scott Haydon, M.D.**  
**FINANCIAL POLICY**

Dr. Haydon has a responsibility to provide quality healthcare services to patients. In the interest of maintaining a good doctor-patient relationship and continuing the delivery of quality healthcare, it is our hope that you will take responsibility for your financial obligation to our practice. The following are general policies we have established for our patients, which we believe allow the flexibility that some patients need. We encourage you to discuss your account, and any payment arrangements that you desire, with our office personnel. Discussion of these issues early on in your treatment process will prevent most concerns or misunderstandings.

**1. Insurance** – As a courtesy to our patients, we will file claims on all visits and procedures, whether they are delivered in our office or the hospital. When we file a claim on your behalf, it is with the understanding that benefits will be assigned to Dr. Haydon (that is, the insurance company will reimburse Dr. Haydon directly). **We do require pre-payment of an estimated amount to Dr. Haydon prior to any scheduled procedure based on the procedure codes and your benefits with your insurance plan.** You are responsible for payment of all deductibles, co-insurance and non-covered services. Please remember insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you.

**2. Referrals** – You are required to 1) know whether or not your insurance requires a referral and 2) obtain that referral before you are scheduled to see our physician. Our office will be happy to assist you in determining the status of Dr. Haydon on your insurance plan; however, this is not a guarantee of coverage. You should take the time to call your insurance company to ask specifically about Dr. Haydon and your covered benefits. Referrals typically have an expiration date and a limited number of visits so you should be careful to monitor the dates and visits. Our office will not see a patient who does not have a valid referral.

**3. No Insurance** – Patients who do not have insurance are expected to pay for all services rendered prior to surgery. We will request all payment for cosmetic procedures in advance of having the procedure performed. We understand that individual situations may make it difficult to meet these financial expectations and are happy to discuss third party financing with you.

**4. Returned Checks** – Your account will be charged a \$20 fee for each returned check. In addition, you will be asked to bring cash to our office to cover the returned check and the fee.

**5. Past Due Accounts** – Patients who have not made an effort to make payment arrangements or have not expressed an interest in meeting their financial obligation to us will be turned over to a collection agency. Patients who have allowed their account to be turned to an agency will be expected to satisfy their financial obligation to us, and to pay for any future services in advance, before being seen by Dr. Haydon.

**6. Non-Covered Services** – You have scheduled a visit with Dr. Haydon that he believes to be relevant to evaluate, monitor and protect your health. However, Medicare and certain other insurance companies will only pay for services that they determine to be “reasonable and necessary”. If Medicare or another insurance company determines that your visit with our physician is not “reasonable and necessary”, they will deny payment for that service. Dr. Haydon recommends an office visit prior to the performance of any procedure, in order that the patient’s general health may be evaluated and so that the patient is well informed about any recommended procedure. We are required to inform you that your insurance company may not cover the office visit and that you will be responsible for payment.

**Patient Statement:**

I have been informed of Dr. Haydon’s financial policy and agree to its terms. I have been notified that Medicare and other insurance companies may deny payment for my initial office visit for the reasons stated above. If Medicare or my insurance company denies payment, I agree to be personally and fully responsible for payment. I understand that all cosmetic surgery must be paid in full prior to surgery.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If patient is a minor:

\_\_\_\_\_  
Guardian or Parent

\_\_\_\_\_  
Date