

IOWA PLASTIC SURGERY

4334 East 53rd Street Davenport, IA 52807 Phone: 563.322-8877 Fax: 563.322-8375

PAYMENT AGREEMENT CONSENT INSURANCE ASSIGNMENT/RELEASE WAIVER

Please Read Carefully

In consideration of the medical services provided to and/or treatment of the "Patient" by "Iowa Plastic Surgery, P.C." ("Provider"), the person(s) ("Undersigned") signing this Agreement agrees to the following:

1. **Agreement to Pay Charges.** The Undersigned promises to pay to Provider the total charges, on demand, for services rendered. The Undersigned agrees to pay the charges that are listed in the current Provider fee schedule, which is available for inspection on request and are incorporated in this receipt by reference. The Undersigned also agrees that all charges for goods provided and services rendered that are not covered by any insurance program, sponsorship, or other third party coverage are due and payable at the time of services. The Undersigned acknowledges that Provider will not bill any insurance carrier or other third party payer, and it is the responsibility of the Undersigned to apply for any insurance reimbursement. Any amounts paid by insurance companies, assigned to and received by Provider, will be credited to the balance due, but the Undersigned will be liable to pay any charges not paid by insurance. The assignment of insurance benefits does not alter the Undersigned's obligation to pay. Provider reserves the right to decline further services to the Patient without notice and to accept periodic payment without waiving its right to demand payment in full as outlined above and the right to assign the amount due under this Agreement. Any overpayment by or for the Patient will be first applied to other balances due, and then may be refunded to the paying party or held on account at the request of that paying party. The Undersigned acknowledges having been told by Provider that he or she may be billed for all services rendered. The Undersigned further agree that, if he or she is more than 30 days delinquent in the payment of any bill, interest on the amount due may accrue at the maximum rate allowed by law.
2. **Goods and Services.** The Undersigned acknowledges that the Patient will receive goods and services from the Provider during the visit as ordered by the Patient or the Patient's physician. Payment for all such goods and services shall be made as provided above.
3. **Itemized Patient Bill.** Upon request, the Undersigned will receive a copy of an itemization of charges for all goods and services provided or rendered by the Provider.
4. **Payments.** The Undersigned agrees to pay the full balance of the Patient's account.
5. **Assignment of Benefits.** The Undersigned irrevocably assigns to the Provider any and all rights which the Undersigned have against any insurance company or other third party for payment of the Patient's bill to the Provider. The Undersigned authorizes the application of any overpayment to any unpaid bill due the Provider. The Undersigned further authorizes his/her attorney to remit to the Provider proceeds from any settlement or judgment made or received on the Patient's behalf to pay any balances due to the Patient's account.
6. **Medicare Patients.** The Undersigned understand that Provider goods and services may not be covered by Medicare and the Undersigned agrees to pay for all goods and services that are not paid for by Medicare. The Undersigned also certifies that the information given by him or her in applying for payment under Title XVIII of the Social Security Act is correct to the best of his or her knowledge. The Undersigned authorized the holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. The Undersigned requests that payment of authorized benefits be made on his or her behalf. The Undersigned understand that the care and services received during the Patient's treatment are subject to professional medical review according to the Federal Law P.L. 97-248, and that the information regarding the Patient's treatment may be forwarded to the appropriate peer review organization, which will ensure the confidentiality of information collected and maintained for purposes of professional review.
7. **Collection Costs.** The Undersigned further agrees to pay and be responsible for all collection costs at the time such bills are forwarded to collection, in addition to reasonable attorney's fees, costs and court costs, as well as any other expenses that Provider may incur in collecting any unpaid bill which the Undersigned or the Patient incurred for services rendered by the Provider.
8. **Release of Information.** The Undersigned consents that relevant information on the Patient's medical record and (when specifically requested) copies of any pertinent medical record information may be given to any insurance company or third party payer for the sole purpose of securing payment of the Patient's bills. The Undersigned further consents that the Provider may access and retrieve credit information regarding the Patient and the Undersigned from any licensed credit bureau.
9. **Miscellaneous.** If the Undersigned is not the Patient, the Undersigned represents and warrants that they have full legal authority to sign this Agreement on behalf of the Patient. All individuals signing this Agreement as the Undersigned shall have joint and several liabilities for all amounts due to Provider for the care and treatment given to the Patient. If the Undersigned fails to make any payments when due, the Provider may at any time thereafter, without notice or demand, declare the entire unpaid balance of the account to be immediately due and payable. This Agreement and the obligations, consent, and information releases shall be binding upon the Patient's heirs, executors. And administrators.
10. **Notice to Undersigned.** Do not sign this Agreement before you read it. All terms and conditions of this Agreement shall be valid and binding upon the Undersigned for any present or future services provided to the Patient by the Provider. The Undersigned hereby acknowledges receipt of a copy of this Agreement.

Date Patient Signature Printed Patient Name

Insured's Signature- Parent, Guardian or Guarantor Printed Guarantor Name