LAWRENCE MARTIN MD, FACS
COSMETIC AND RECONSTRUCTIVE FACIAL PLASTIC SURGERY
ENT - HEAD AND NECK SURGERY
Diplomate of the American Board of Otolaryngology-Head & Neck Surgery
Diplomate of the American Board of Facial Plastic and Reconstructive Surgery

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General Consent and Acknowledgement Form

Patient Name: _____ Date: _____

Financial Policy

1. **FULL PAYMENT OF CO-PAYMENT AND PREVIOUS BALANCE IS DUE AT THE TIME OF SIGN-IN. We accept cash, checks, Visa or MasterCard.**
2. If you do not have a managed care plan with which we have a contract, payment is expected at the time of service, and you will be responsible for submitting a claim to your insurance company. We will submit claims to your insurance company only if you are in a managed care plan with which we are contracted. After your insurance company has paid its share, you will be billed for any remaining balance that they indicate is your responsibility. Some of the services provided by our office may not be covered under your co-payment and might be subject to your deductible.
3. You are responsible for knowing if we are in your plan and for fulfilling the requirements of your policy-referrals, co-payments, pre-certifications, etc. If you do not meet these requirements you will be responsible for the entire fee.
4. We do not recognize third-party payer. Therefore:
    a. If the patient is the child of divorce parents, the parent who brings the child to the office will need to present accurate insurance information and responsible party information.
    b. If the patient is being seen as the result of an accident, the patient is expected to provide the insurance information.
    c. If the patient is being seen for a Worker's Compensation case, written authorization from his/her employer is required and should include the name and address to which the bill should be sent.
5. ***FOR ALL PATIENTS WHO FAIL TO KEEP A SCHEDULED APPOINTMENT THERE WILL BE A CHARGE OF $50.00 UNLESS 24 HOUR NOTICE IS GIVEN.***

Patient Rights and Responsibilities and Confirmation of Appointments

I have read and understand the above *Financial Policy*	_____yes	_____no
I have read a copy of the *Notice of Privacy Practices*	_____yes	_____no
I give you permission to call to confirm appointments	_____yes	_____no
You may call or leave a message at work	_____yes	_____no
You may call or leave a message at home	_____yes	_____no
You may contact me via email	_____yes	_____no

If yes, my email- address is: _____

You have my permission to discuss my healthcare with: (family member's name) _____

_____if you are unavailable when we call, may we leave that information with

the above family member? _____

I have read and understand the Notice of Privacy Practices and the Financial Policy of Lawrence Martin, M.D., S.C.. I agree to the conditions stated therein. I authorize my insurance company to send payment directly to Lawrence Martin, M.D. for all services.

_____

Patient/ Parent's Signature Date

_____

Witness Date