Eric S. Rothenberg M.D. F.A.C.S.,

Aesthetic and Reconstructive Plastic Surgery
Surgery of the Hand

Date:_______________

Office Policy

If for any reason (I.E. policy exclusion) insurance **DOES NOT PAY**, even though prior-authorization has been obtained, then **I**, the patient, will be responsible for **ALL CHARGES INCURRED** for office visits, surgical procedures, hospital, and anesthesia.

All balances after 90 days will be turned over to a collection agency, unless prior payment arrangements have been made

I, the patient**, at time of scheduling** a surgical procedure will be responsible for **the amount of my coinsurance or the remaining portion of my deductible**. If I am unable to pay this amount then I understand that my procedure cannot be scheduled.

Patient's Name:____

DOB:__________________________ **SS#:_______________________________**

Signature:____________________________________Date:_________________________