North Star Plastic Surgery, LLC
562 University Ave, Suite 101
Fairbanks, AK 99709
Ph: (907)415-1884
Fax: (855)678-0909

Disclosure of Charges

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize North Star Plastic Surgery, LLC to release to my insurance companies, employer insurance groups, health plans, Medicare, Medicaid, or any intermediaries, or physicians associated with the center and any billing or collection agents of North Star Plastic Surgery, LLC, any medical or financial records or other information concerning this treatment to obtain reimbursement on by behalf of the treatment and services provided to me by North Star Plastic Surgery, LLC.

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE

I hereby authorize payment to be made directly to North Star Plastic Surgery, LLC for insurance benefits payable to me. I understand that I am financially responsible to North Star Plastic Surgery, LLC for any covered or non-covered services, as defined by my insurer, which are not paid by my primary or secondary insurer. I also understand that if my account balance becomes overdue and the overdue balance may be added to the amount due and that I am financially responsible for the added collection fee and any reasonable attorneys' fees and other costs incurred for collection.
Because North Star Plastic Surgery, LLC is not contracted with some insurance companies, they may send me a check for services provided by this office. I hereby confirm that I will forward any check issued directly to me to the office for payment of my medical bill. **I will bring the insurance check to North Star Plastic Surgery immediately and I will endorse the check to North Star Plastic Surgery.** In the event that I do not remit the check I understand that I may be turned over to a collection agency, you will be responsible for the collections fees as well.

NOTICE AND ACKNOWLEDGEMENT OF HIPAA

I verify that I was provided with and consent with the following information prior to my procedure/office visits:

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE NOTICE, AND ACKNOWLEDGEMENT OF HIPAA.

Name:_____

Signature:_____ Date:_____