THE CENTER FOR COSMETIC SURGERY &

DEAN P KANE, MD, FACS, PA
LAURI P KANE, RD, MPH, SCD

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Practice Authorizations and Policies

I / we acknowledge that Dean P. Kane, MD, FACS, PA (Practice) no longer participates with medical insurance companies. Both “insurance-pay” and “self-pay” procedures are offered, I remain personally and fully responsible for immediate payment of all fees. Should I / we wish to submit a claim for reimbursement of “insurance-pay” services from my insurer, I will request a receipt within 30 days of the services rendered. Payment for cosmetic services are irrevocable.

________ initial

I / we understand that I / we personally guarantee to be financially responsible to pay for any and all charges not covered by my insurer. As a guarantor, I /we fully accept the medical services provide to me / the patient. I also remain totally responsible to the bill if my insurer including Medicare or HMO’s, PPO’s and the like deny payment as deemed not necessary, not reasonable, cosmetic or otherwise. In the event collection efforts are required to obtain payment of the charges incurred by me / the patient, I / we agree to pay any costs incurred in the collection of this account including but not limited to court costs, private processing service fees and the like. All persons executing this form are guarantors and agree that their obligation to pay is joint and several in nature.

________ initial

I / we understand that “failure to show” (FTS) for an appointment imposes a great burden on the Practice. Forfeiture of a pre-paid service or a FTS fee will be collected for the date missed prior to new services provided.

________ initial

The practice of medicine and surgery is not an exact science. I / we acknowledge that no guarantees have been made to me as to the results of any treatment, procedure or product. Although good results are desired, there cannot be any guarantee or warranty expressed or implied on the result(s) that may be obtained. Dissatisfaction with any result does not constitute a basis for reimbursement, refund nor cancellation of payment. Regret, remorse, anguish or any other show of apology does not express any admission of fault nor constitute a show of guilt, liability, error or blame. Should complications or dissatisfaction occur, additional surgery or other treatments may be necessary. Your insurer may not cover the cost of complication(s), side-effect(s) or revisional therapy for elective cosmetic procedures. You should expect additional fees and these fees may be non-refundable. Risk of complications and side-effects may occur with primary and any additional procedures. I agree to be personally and fully responsible for all fees.

________ initial

Services performed that are paid for with a credit card, debit card or with financing, are not eligible for post-care payment challenges. I agree that this credit, debit card or financing challenge agreement is irrevocable. Your Protected Health Information will be used if required to recover a practice expense claim.

________ initial

Red Flag Rules and Anti-Fraud Regulations require that we request and maintain a minimum of 2 (two) current identifications; one photo-ID such as a driver’s license and a second non-photo or photo ID.

________ initial

I / we consent to the use or disclosure of my individually identifiable health information (“Protected Health Information”) as defined in this offices “Notice of Privacy Practices” by Dean P. Kane, MD, FACS, PA in order to carry out treatment, payment, or health care operations. A “Notice of Privacy Practices” is available for my review.

________ initial

I / we acknowledge that it is the policy of the practice of Dean P. Kane, MD, FACS, PA to follow all federal and state laws and reporting requirements regarding Identity Theft. I / we will provide all necessary documents to prove the authenticity of my identity. Should there be any claim or concern of Identity Theft, I / we will report or the incident will be reported to the appropriate authorities. Should I / we wish to defer these policies, all products, services and surgery may be provided with a cash payment only.

________ initial

I / we hereby authorize Dean P. Kane, MD, FACS, PA and his associates to take photographs, slides, videotapes and other documentary images, quotations or testimonials during my care. Digital Imaging or HIPPA protected information other than medical documentation will be requested under separate authorization.

________ initial

It is the policy of Dean P. Kane, MD, FACS, PA to protect your digital communication to and from our practice.
I / we acknowledge that current technology may not fully conceal and / or protect the confidentiality of your identity with email, social media or other digital contact. I will not hold Dean P. Kane, MD, FACS, PA, Dean P. Kane, MD, FACS nor any employees or contractors responsible for a breach in such communication.

________ initial

I / we are aware that many prescription medications sold by this “Practice” maybe available by at local pharmacies. I have chosen to purchase said medications at the “Practice” location for my convenience.

________ initial

By signing below, the undersigned certifies that the foregoing paragraphs have been read in full, are understood and agreed upon by the undersigned.

By signing below, the undersigned certifies that ALL information provided to the Practice is truthful and up-to-date.

Signature:____________________________________(Seal), Date:________________________

Refusal to sign acceptance to the above items indicates non-compliance by the patient / surrogate / guarantor to the policies of this practice and elective, non-emergency services will not be provided.