THE CENTER FOR COSMETIC SURGERY & medi Spa

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

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Practice Authorizations and Policies

The practice of medicine and surgery is not an exact science. I 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 is no 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 or cancellation of payment. Regret, remorse, anguish or any other show of apology does not express any admission of fault or 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

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 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 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 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 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 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

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. I agree and authorize the use of my credit card on file to pay for unpaid services.

_____ initial

Red Flag Rules and Anti-Fraud Regulations are followed. We require a minimum of 1 (one) current photo-identification such as a driver's license and a second non-photo ID for proof of identity.

_____ initial

I 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 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 will provide all necessary documents to prove the authenticity of my identity. Should there be any claim or concern of Identity Theft, The Practice will report the incident to the appropriate authorities. Should I wish to defer these policies, all products, services and surgery may be provided with a cash payment only.

_____ initial

I hereby authorize Dean P. Kane, MD, FACS, PA and his associates to **take photographs, slides, videotapes and other documentary images, quotations or testimonials during and for documentation of 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** to the best of our ability**.** I 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 am 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

I am made aware that the Dean P Kane, MD, FACS, PA follows **2017 Maryland Heroin and Opioid Prevention, Treatment, and Enforcement** Initiative has mandated an Opioid Education, Discovery and Consent process for those patients who receive peri-operative controlled substances prescriptions.

_____ initial

I acknowledge that this Practice provides medical and surgical services during the COVID-19 pandemic and may expose me and those around me to the SARS-CoV-2 virus. I will not hold Dean P Kane, MD, PA or his employees responsible should I develop COVID-19 or resultant complications and remain financially responsible to all its complications. I have read, understand and signed the additional COVID-19 screening questionnaire and consent form(s).

_____ initial

I acknowledge that this Practice **recommends me to obtain an executed Power of Attorney and Advanced Directives** with an appropriate attorney..

_____ 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:_____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.

It is our desire to provide the best opportunity to meet your desired expectations. When these expectations are not met and disappointment occurs, misunderstandings in the transfer of information is usually the cause. Disparaging remarks to or about the Practice on any social media platform including word-of-mouth helps no one! It doesn't help you as your issue is not addressed and it does not help the Practice or its members as I can assure you the incident is rare and does not help address a change if needed.

When wrongful remarks are made, it is legally considered to be slander and libel and may initiate legal action. This again, helps no one as it escalates rather than fixes the misunderstanding and miscommunication. Please notify us if there is any misunderstanding.