Financial Policy, No Surprise Billing

Dr. Keelee J. MacPhee, MD, PA are dedicated to providing you with the best possible treatment. We regard your understanding of our financial policy as an essential element of your overall healthcare. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with us.

Dr. MacPhee is not in network with any insurance companies except Medicare. Your insurance contract is an agreement between you and your insurance carrier. We will do our best to help you navigate the process of using insurance if you have the benefits for surgical coverage.

All surgeon fees for your elective surgery are required in advance of the procedure. You will sign a Good Faith Agreement form with the surgeon fee before the day of surgery. The hospital will provide you with estimated anesthesia & facility fees as their own good faith estimate.

If you are trying to have your elective surgery covered by Non-Medicare insurance, then we require a non-refundable, $250.00 administrative fee for patients requesting our assistance trying to have surgery pre-authorized, pre-determined. We will provide a superbill for you to use in submitting your claim to your insurance. **We only send COURTESY claims to insurance, in order to help you to receive as much as possible of your patient refund.**

A $25.00 returned check fee will be assessed to your account for every check returned to our office for insufficient funds. Patients issuing two NSF checks must make all future payments by cash or credit card.

For reconstructive and cosmetic patients, there is no guarantee of results or outcome. If additional procedures are undertaken, then the patient may be fully responsible for facility, anesthesia and surgeon fees.

We reserve the right to turn any patient over to collections if it is deemed that the account has been in default of payment obligations or for noncompliance of the policy. Patients previously sent to collections are required to pay old balances in full and for all future visits. Patients who do not comply with this policy may be dismissed from this practice. Only emergency care will be provided for a 30 day period after dismissal, at which time the patient should have been established with a new physician.

For all services rendered to minor patients, the adult accompanying the patient is responsible for the payment.

I have read and understand the financial policy of this practice. I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by this practice. I hereby authorize Dr. to release information acquired in the course of my examination / treatment to my insurance carrier for medical care. I will not dispute charges presented to me for the surgeon fee on the good faith estimate. I agree to be responsible for payment of services determined not to be medically necessary or non-covered by my insurance carrier.

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Please Print Name

_____ _____
Signature of responsible party Date