Dr. Matthew H. Conrad
1700 Waterfront Pkwy Bldg 200 Wichita, KS 67206

Patient Financial Policy

Thank you for choosing the office of Dr. Matthew H. Conrad. Our primary mission is to provide our patients with outstanding medical care. We are committed to providing state of the art treatment and care. Your clear understanding of our Patient Financial Policy is important to us. Carefully review the following information and return this form with your signature and today's date. Please ask if you have any questions about our fees, our policies and/or your responsibilities. Thank you for choosing Dr. Conrad's office for your medical care.

We request all patients complete our Patient Information Form prior to seeing Dr. Conrad. Please notify our office of any patient information changes (i.e. address, name, insurance information, etc.)

We accept cash, personal and certified checks, Master Card, Visa, American Express, and Care Credit. You may receive bills from outside pathology and laboratory clinics that we utilize.

Insurance patients: As a courtesy to you, we file your claims to your insurance company. Amounts not covered by your insurance are your responsibility. **ALL CO-PAYMENTS MUST BE PAID AT THE TIME OF SERVICE. IF YOU DO NOT HAVE INSURANCE, PAYMENT IN FULL IS EXPECTED AT THE TIME OF YOUR VISIT UNLESS PRIOR ARRANGEMEMTS HAVE BEEN MADE.**

Cosmetic Patients: All cosmetic procedures performed by Dr. Matthew H. Conrad must be paid in full **21 days** prior to surgery.

FINANCIAL AGREEMENT

Please read and initial each line

I understand that my insurance company or payer of my health benefits may pay less than actual charges for services. I understand I am financially responsible for payments in full, of all co payments, deductibles and/or remaining balances as specified by my insurance plan. If payment is denied or not covered by my insurance, or I have no insurance, I agree to be responsible for payment in full. _____

I understand that payment for cosmetic surgery is due **21days** prior to the date of surgery. _____

I understand that outstanding balances are due when statement is received. _____

I understand and agree that I am responsible for payment of all charges on my account. _____

I understand that treatment and/or revisions of undesired results, unforeseen occurrences and/or complications have additional costs. _____

I understand and agree that plastic surgery outcomes and patient satisfaction cannot be guaranteed. _____

I understand and agree that if my account is placed into collection action, I will be responsible for all the costs of such action (collection agency and attorney's fees included.) _____

All accounts over 120 days will be assessed 10% interest annually. _____

Missed, changed, cancelled or rescheduled surgery appointments have additional costs. _____

There is a $30.00 fee for any check returned for insufficient funds. _____

I have been informed of Dr. Matthew H. Conrad's Financial Agreement policies. _____

Signature of Responsible Party _____Date _____

Witness _____Date _____