AESTHETIC SURGERY

RONALD A. LOHNER, M.D., F.A.C.S.
CERTIFIED AMERICAN BOARD OF PLASTIC SURGERY

RECONSTRUCTIVE SURGERY

Authorization
Financial Responsibility

I authorize the release of my medical records to my insurance carrier in the event copies of these records are requested by my insurance carrier(s)

_____ Date:_____

I understand that my insurance policy states I will have a co-pay and/or deductible related to my office visit(s) or my surgery (ies) with Dr. Lohner. I understand I am legally responsible for any and all co-pays and deductibles.

_____ Date:_____

I request that you file claims with my insurance carrier(s) for testing, treatment and procedures, and authorize payment by my insurance carrier directly to you.

_____ Date:_____

I acknowledge and accept financial responsibility for all testing, treatment and procedures performed in the event these are not covered, excluded or denied by my insurance carrier(s)

_____ Date:_____

If I require disability papers to be completed, I understand there will be a $20 charge for EACH form that needs to be filled out. I understand this fee will be paid in advance of the papers being completed.

_____ Date:_____

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