Herrera Health Services
Aryeh L. Herrera, M.D., F.A.C.S.

ARYEH L. HERRERA, M.D., F.A.C.S.
BOARD CERTIFIED
PLASTIC & RECONSTRUCTIVE SURGERY

GENERAL RECONSTRUCTION
MICROVASCULAR SURGERY
MAXILLOFACIAL SURGERY
HEAD AND NECK CANCER
HAND SURGERY
WOUND CARE

Patient Agreement

1. It is your responsibility to understand your insurance benefits. If you are unsure if a service or treatment is covered you should contact your insurance carrier. We do not provide information about insurance policies. If your insurance card indicates that you have a copayment, that amount is due at the time of your visit. If there is an additional balance due, you will receive a bill from us for payment.
2. If you have a deductible that has not been fulfilled, this will be collected at the time of service for services rendered.
3. We will accept your payments in cash, check, Visa, MasterCard or American Express.
4. There will be a $30.00 returned check fee.
5. If an account becomes delinquent, you will be subject to late interest charges at the rate of 1.5% monthly or 18% annually. Delinquent accounts may be sent to an outside collection agency or pursued through small claims court. You will be responsible for all court costs, attorney fees and/or collection agency fees.
6. We accept most insurance plans and as a courtesy, file all claims electronically for you.
7. You are responsible for any/all charges not paid by your insurance carrier, which also include denials of claims for rendered services.
8. We will also electronically send all claims to any secondary or supplemental payers, if payment is not received from them within 60 days of submission, a bill will be sent to you for payment in full.
9. If we do not accept your insurance plan, payment and claim submission for reimbursement is your responsibility.
10. It is your responsibility to provide correct insurance information to this office. If we are unable to bill your insurance in the window of timely filing due to lack of necessary information, you will be responsible for costs of treatment. ALL insurance cards should be present at the time of service.
11. If your insurance company requires a referral for a specialist, you must obtain this referral from your primary care physician prior to your appointment.
12. If you request your medical records from our practice, there will be an assessed administrative fee of $22.88 plus $.76 per page.
13. All medical forms that need to be filled out by a physician have an assessed fee of $50 that is due prior to completion.
14. We will call and confirm your scheduled appointments 2 days in advance, if you confirm this appointment and do not show or cancel; an assessed $50 fee will be billed to you for payment.
15. Any questions regarding your account should be addressed by our billing clerk at 301-739-7790.

324 ANTIETAM STREET, SUITE 306B
HAGERSTOWN, MARYLAND 21740
301-739-7790 • FAX (301) 739-4093

Herrera Health Services
Aryeh L. Herrera, M.D., F.A.C.S.

ARYEH L. HERRERA, M.D., F.A.C.S.
BOARD CERTIFIED
PLASTIC & RECONSTRUCTIVE SURGERY

GENERAL RECONSTRUCTION
MICROVASCULAR SURGERY
MAXILLOFACIAL SURGERY
HEAD AND NECK CANCER
HAND SURGERY
WOUND CARE

By signing below, I certify that I have read and understand the above information. Any questions concerning these policies have been discussed and I have received my own copy of the policies listed. My signature also certifies my agreement with the above listed policies and authorizes this office to release information to any agency or insurance carrier for payment of services rendered. A photocopy of this document is as valid as the original.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Witness to Signature: _____ Date: _____

Consent to Taking of Photographs and Video

In connection with the medical services which I am receiving from Herrera Reconstructive Surgery, I consent that photographs or videos may be taken of me or parts of my body; under the following condition:
These photographs shall be used for medical records only, unless, in the judgement of my physician, medical research, education or science will be benefited by their use. In that event, I agree that they may be used for such purpose, provided that my identity is not revealed by descriptive texts accompanying them.

Patient and/or Guarantor Signature: _____

Witness to Signature: _____

324 ANTIETAM STREET, SUITE 306B
HAGERSTOWN, MARYLAND 21740
301-739-7790 • FAX (301) 739-4093