Daniel T. Holley, M.D.

Financial Policy:
Insurance:

Our continued participation in your health plan depends upon everyone fulfilling his or her obligation in accordance with the contracts. Patients are responsible for all deductibles, co-payments, coinsurance and non-covered charges. As a service to our patients, we call your insurance to get a description of benefits. This office is not responsible for incorrect benefit information given to us by your insurance carrier, or changes after verification date. A description of benefits is not a guarantee of coverage and cannot be relied on as such. In the event of non-payment by your insurance company the charges on your account will be your responsibility. We accept Visa, MasterCard, American Express, Care Credit, Personal Checks and Cash for your convenience. All co-payments are due at the time service is rendered. If you want to verify the insurance benefits quoted, please call your insurance company.

Cosmetic:

COSMETIC PROCEDURES ARE NOT COVERED BY MEDICARE OR HEALTH INSURANCE.

Our office policy is to take a credit card number as a booking fee for your cosmetic consultation. We do not charge for cosmetic consultations, however if you do not cancel your appointment 24 hours prior or do not show for this appointment, we will charge your credit card $100. Once you come in the office, we will delete your credit card information from our system.
Dr. Holley's fee is due the day the consents are signed (2 weeks prior to surgery). If you must cancel your surgery, please do so within seven days of your surgical date, otherwise there will be a $500.00 cancellation fee. We accept Care Credit financing, restrictions apply. Fees decrease 2% for Cash & Checks only!

PATIENT CONSENT: I hereby give consent for medical treatment for myself or I am duly authorized by the patient as his/her legal guardian to consent for such treatment.
ASSIGNMENT OF BENEFITS: I hereby authorize payment for medical benefits directly to Daniel T. Holley, M.D., P.A. for the services rendered.
RELEASE OF INFORMATION: I hereby authorize the release of any medical information necessary to process any insurance claims.

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Signature Patient/Legal Guardian Date