Financial Policy - Elective Procedures

- Payment in full for each visit is due unless financial arrangements have been made.
- This office will accept the following instruments for payment of services rendered: Cash, Check, American Express, Discover, MasterCard, and Visa. Optional financing plans are also available. We will be happy to assist you with applying for financing should you so desire. We have an excellent relationship with financial programs and can accelerate the approval process for qualified patients.
- In order to schedule a procedure and to secure your desired date, we must obtain a $250.00 **non-refundable** deposit. The remaining balance of the fees will be due at your pre-operative visit or two weeks prior to your procedure. The deposit will be applied to your elective procedure; however, if the procedure is canceled for any reason, this balance is also **non-refundable** except in the case of documented emergency or medical disability. If your scheduled date is changed within 3 three weeks of your procedure, an additional $250.00 deposit is required.
- If revisionary treatments are desired during the first year, there will be no surgeon's fee; however, the cost of surgical supplies, facility fee, and anesthesia will be the responsibility of the patient. Any further treatment will reflect the usual procedural fees.
- There is a $25.00 charge for post-operative appointments after 90-days from your surgical date. These global care standards are set forth by the American Medical Association.
- Any lab work required for your elective procedure will be the sole responsibility of the patient.
- Overpayments will be processed and refunded to the appropriate party according to generally accepted procedures. Refunds due to the patient/guardian will not be processed and remitted until all active and past due, including bad debt, accounts have been paid. This process generally takes 60 days.
- It is our policy to charge a $25.00 fee for all returned checks.
- Please be aware that under **no circumstances** does this office file insurance for elective cosmetic procedures. This applies regardless of participation in patients plan. Patient understands and accepts that this office will assist in providing a receipt of services rendered on day of surgical procedure. Any reimbursement received by insurance plans will be patient's responsibility and patient understands that for such cosmetic procedures, negotiated rates will not apply.
- All patients are charged the same for same services rendered and this office does not accept reasonable and customary charge calculation by outside parties unless provided in an arrangement such as a managed care contract.

I have read and agree to the above policies. I understand that it is my responsibility to pay any fees due to this office.

HIPAA Acknowledgement

By signing below, I acknowledge that a copy of this practice's **Notice of Privacy Practices (HIPAA)** is available to me at my request and I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of Patient/Patient's Guardian: _____ Date: _____