SARASOTA PLASTIC SURGERY, INC. CENTER FINANCIAL AGREEMENT

Surgical Fees & Cancellation Policies

- Payment is due in full 3 weeks (21 days) prior to the scheduled surgery date. We accept Visa, Mastercard, Discover, American Express, CareCredit/Alphaeon, and Cashier Checks/Personal Checks. *WE DO NOT ACCEPT CREDIT CARD CHECKS.* All personal checks will be processed through TeleCheck as an electronic transfer.
- If your surgery is cancelled or postponed 3 weeks (21 days) prior to surgery, your fees will be refunded. If your surgery is cancelled within the 3 weeks (21 days), you will be charged a $500.00 administrative fee and a fee for any services provided; such as laboratory work or skin care services. If your surgery is cancelled within seven (7) business days of your surgical date, an additional administrative fee of 25% of your total charges will be withheld from your refund. If your surgery is cancelled the day of the procedure, you will be charged 50% of the total charges.
- In the event that revision surgery is needed or you experience a complication following surgery, you may incur additional fees.
- *All tissue that is removed during surgery will be sent to Pathology and the patient will be responsible for these charges. It is the patient's responsibility to notify us regarding where their insurance prefers pathology to be sent to avoid out-of-network charges.*
- If postponing a surgery more than two (2) times, a 50% deposit will be required to hold a new surgical date and will be forfeited if date needs to be changed. In addition, such changes could result in dismissal from our practice at the surgeon's discretion.
- The services that are performed and paid for using a credit card or debit card are not eligible for credit card challenge. By signing this form, you are agreeing you will not challenge credit card payments once a service has been rendered. The practice encourages a complete post-op care and follow-up interaction to address any issues that might arise following services rendered.
- **The policies listed above will be applied in every situation.**

As a courtesy, we attempt to remind patients by phone of their scheduled appointments. However, it is the patient's responsibility to keep his/her appointments whether or not a reminder call is received.

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guarantee the payment of all amounts when and as due.

A photocopy of this agreement shall be considered effective and valid as the original.

DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS. MY SIGNATURE BELOW INDICATES I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS STATED IN THIS FINANCIAL AGREEMENT/CANCELLATION POLICY.

Patient Date

Witness Date

REV 3/19