

Pelosi Medical Center
COSMETIC SURGERY FINANCIAL AGREEMENT

DATE: ___/___/___

PATIENT'S WEIGHT: _____ LBS

PROCEDURE	FEE*
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
5. _____	\$ _____
6. _____	\$ _____
Facility Fee	\$ _____
Anesthesia Fee	\$ _____
Total	\$ _____
Less Deposit	\$ _____
Balance Due	\$ _____

Methods of Payment

- Cash, personal checks, cashier's check, traveler's check, and money orders. There will be a \$20.00 service charge on returned checks.
- Credit cards: Visa, MasterCard, American Express and Debit Cards.
- Financing is available through CareCredit.com.

Cost of Surgery

The date of consult constitutes the day of the quote. The quoted surgical fee remains valid provided that: (1) the surgery is scheduled and the deposit is paid within six months of the date the quote was made, (2) the surgery is done within six months of the quote, and (3) the patient's weight does not increase by more than 5% after the time of the quote. The balance of the total fee must be paid **ONE MONTH** prior to your scheduled surgery date.

Scheduling Deposit

To reserve a day for your surgery, a \$500.00 deposit is required. This is credited toward your actual surgery cost.

Patient Initials: _____

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Cancellation and Refunds

Please understand that the Pelosi Medical Center must uphold these policies as we have an obligation to our patients who may have requested the same day and to our surgical team and anesthesiologist who are scheduled to work. Also, there are numerous medical supplies that are ordered specifically for your surgery.

If you cancel your surgery **within 14 (fourteen) days** of your scheduled procedure, there is a \$500.00 cancellation fee.

If you cancel your surgery **within 3 (three) days** of your scheduled procedure or fail to attend on your scheduled surgery date, there is a \$1,000 cancellation fee.

The balance of your surgery pre-payment will be refunded in full by business check within 30 days. This time is required to ensure all pre-payment transactions have cleared and are validated by the appropriate financial institutions.

There will be no refund for services already provided.

Touch Up Procedures

Patient understands that liposuction and abdominoplasty are not weight reduction procedures. Patient understands that to maintain their newly contoured body shape, a commitment is required to change eating habits in order to avoid weight gain and loss of the newly contoured body shape.

A touch up procedure is additional work of the same type and on the same area(s) done at the original procedure for the reason that a reasonable aesthetic result was not achieved at the time of the original procedure. There is a facility fee of \$500 for all touchup procedures. However, there will be no additional surgical charge for the touchup procedure under the following conditions:

1. The touchup procedure is performed within six months of the original procedure
2. The patient’s weight remained the same since the date of the original procedure
3. The procedure is not a request for additional fat injections in any area treated with autologous fat transfer at the original procedure
4. The touchup procedure is for the same body area as the original procedure

If any of the above conditions are not met, there will be a surgical fee for the new/redo procedure. If the services of an anesthesiologist are required for the touchup procedure, these costs will not be waived by this policy and the patient will be responsible for paying the anesthesiologist fee.

Treatment and Complications

The practice of medicine and surgery is not an exact science. Although good results are anticipated, there can be *no guarantee or warranty, expressed or implied, by anyone as to the actual results you may get.* Surgical revisions and/or other medical treatment or management of problems and/or complications may be required. These may result in additional charges *for which you are responsible.*

****** In the event of default, I hereby agree to pay all costs of collection, including but not limited to attorney fees, court costs, all interest allowed by law, collection agency fees, etc.

I have read and understand the terms of this Cosmetic Surgery Financial Agreement.

Patient Signature

____/____/_____
Date