FINANCIAL POLICY

Effective January 01, 2019, we will request a copy of a Master Card or VISA on your first visit. This will be kept on file for any balance on your account that is over 30 days past due, including co-pays, co-insurance and deductibles. Your credit card information will be secured in our system with no available outside access.

GENERAL APPOINTMENTS: We require a credit card on file to reserve all appointments.
Should a balance be due, we shall send you one statement. Your portion will be due to us within 30 days. This gives you the option, if you prefer, to pay by other means, or to call our office to make payment arrangements if necessary. Any accounts that are over 30 days old will be charged to the credit card we have on file for you.

COSMETIC CONSULTATION AND TREATMENT FEES: Our **Cosmetic consultation fee is $125.00**. Laser and CoolSculpting consultations are FREE. A deposit of $125.00 is required upon scheduling a consultation appointment**. T**his is non-refundable if cancellation occurs within 48 hours. For your convenience, we take cash, checks, Visa or MasterCard. For all procedures that are not covered by insurance, payment must be received at least 2 weeks before **your** procedure.

COSMETIC SURGERY: To reserve a surgical date, a non-refundable deposit equal to 25% of Dr. Dick's total procedure fee must be paid at the time of scheduling. Should you have the need to reschedule within two weeks of surgery, please note that your deposit will be forfeited. A pre-operative appointment will be scheduled at our office within two to three weeks of your surgery. At this visit, the remaining balance of Dr. Dick's surgical fee is due. If cancellation occurs within 72 hours of the surgery date, 75% of the total surgeon's procedure fee is non-refundable. All post-operative visits for the first year are included in the surgical fee. Our office reserves the right to release your surgical date if fees are not paid in accordance with our financial policy.

FEES: Dr. Dick's fees quoted on the cost analysis sheet will be honored for one year. Montgomery Surgery Center (Facility Fee) and US Anesthesia Partners (Anesthesia Fee) offer our practice a "cosmetic rate" and these are noted on your cost analysis sheet. Their fees are based on time and are estimates only. **The Facility and Anesthesia fees** are to be paid separately on the day of surgery.

INSURANCE CONSULTATION/SURGERY: All co-pays are due at the time of your appointment. We will bill your insurance only if we are a participating provider. However, it is your responsibility to verify if we are **in network** with your specific insurance plan. If for any reason your insurance company denies claims on your behalf, it will be your responsibility to pay **your balance in full**. All deductibles, co-pays, co-insurance, non-covered services and all cosmetic balances are ultimately your responsibility. We reserve the right to send unpaid balances to collections, where you will then be responsible for any and all collection fees.
If we perform a procedure in our office, a **deposit of $175.00** is due at the time of service. For all procedures done in the hospital or surgery center, we require a **deposit of $250.00** due at the time of scheduling. These amounts shall be applied to the balance owed by you. Once your insurance company has paid their portion, any credit shall be refunded back to you within 60 days.

COOLSCULPT POLICY:

- We do not offer refunds after services have been rendered.
- $500.00 deposit is required upon scheduling of treatment.
- If cancellation occurs within 48 hours, the $500.00 deposit is non-refundable. These fees can be used towards other services offered at our facility.

*Checks that are returned to us for insufficient funds will be subjected to a service fee of $50.00.

CANCELLATION / NO SHOW POLICY: We understand that your time, as well as ours, is valuable. However, we reserve the right to charge a **$100.00** "no show" and cancellation fee for office appointments not canceled 48 hours in advance.

I have read, understand and agree to all the terms of this financial policy:

Patient Signature_____ **Date**_____

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