

ADVANCED PLASTIC SURGERY CENTER

Richard D. Redman, MD

General and Cosmetic Surgery Financial Policies

Please take a moment to review these policies. We encourage you to ask about any items that you do not understand or feel are unclear. A copy will be provided to you on request.

COSMETIC SURGERY/SERVICES: Payment for cosmetic surgery and related services is due in full 1 week prior to procedure. There is a non-refundable deposit of up to \$500 required to schedule and hold time for cosmetic surgery and services. This fee will be credited toward the cost of your procedure. In office laser services with Dr. Redman require a deposit of half of the treatment fee.

NON-COSMETIC SURGERY/SERVICES: Payment for non-cosmetic services is due at the time of service. This includes co-pays, self-pays, etc.

INSURANCE AND COSMETIC SURGERY: *Cosmetic surgery is a very special kind of surgery which is purely elective and not covered by insurance.* Any attempt to obtain insurance payment for cosmetic surgery or services is fraudulent. Our office will not assist anyone attempting to defraud an insurance company, this office or any other entity; any attempt to defraud may result in civil and/or criminal penalties.

METHODS OF PAYMENT: We accept cash, personal check, money order, cashier's check, traveler's check, Master Card and Visa (debit or credit). Should you wish to finance cosmetic surgery, we can put you in contact with a financing organization.

CANCELATIONS/REFUNDS: If your surgery should be canceled more than 7 business days in advance, your payment will be refunded in full except for your deposit of up to \$500.00. This deposit may be transferred one time if surgery is rescheduled within 90 days. If canceled with less than 7 business days notice, partial refunds may be considered on a case-by-case basis at the discretion of this office. Under certain circumstances we reserve the right to request payment in full prior to rescheduling a surgery. A minimum of 24 hours notice is required to cancel or reschedule an in office laser treatment with Dr. Redman. Should you fail to provide adequate notice, your deposit will be forfeited. **There will be NO REFUNDS for services already provided.**

INSURANCE PARTICIPATION AND FILING: We participate with most locally available insurance carriers. However, it is your responsibility to verify that we participate with your particular insurance carrier and that, if needed, a referral to our office has been made by your primary care physician. If (1) we do not participate with your carrier, (2) you wish to be seen without an appropriate referral, (3) you wish to be seen for a non-covered service, or (4) you are uninsured, full payment will be expected at the time of service. Otherwise, we will be glad to file your insurance claim for you at no cost. **Regardless of our participation status with your carrier, you are responsible for timely payment of your account.**

DELINQUENT ACCOUNTS: Accounts over 60 days old will be subject to submission to a collection agency or attorney and/or national credit bureau(s) for non-payment.

OTHER FEES: A \$25.00 service fee will be charged on all returned checks. A \$25.00 fee will be charged for skincare appointments which are canceled or rescheduled with less than 24 hours notice.

ACCOUNTS INVOLVING DISPUTES: Except where limited by law, you will remain responsible for payment of your account as outlined in the above policies regardless of any disputes, appeals, lawsuits or other action.

ERRORS: If you feel there is an error in your account please notify us immediately so that necessary corrections can be made promptly. It is the intention of this office to adhere to ethical billing and business practices.

EXCEPTIONS (this does not pertain to elective, cosmetic surgery): We understand that unexpected expenses for medical care can cause financial strain. We are happy to work with our patients in these matters where circumstances warrant. Let us know immediately if alternate arrangements need to be made for payment on your account. Alternative arrangements **MUST** be made in writing in advance and agreed upon by all parties.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES: _____
Patient or Responsible Party

Date