

THE PLASTIC SURGERY CENTER OF EAST TENNESSEE

FINANCIAL POLICY

Thank you for choosing Dr. Pastrick and his staff for your plastic surgery needs. We appreciate you entrusting your care to us. The following is a summary of our financial policy.

Responsibility

As a recipient of services through The Plastic Surgery Center of East Tennessee, you are legally responsible for all charges. You may have other means of payment, such as insurance, other third party reimbursement source, or financial agency, but you are responsible for your entire bill.

Methods of Payment

- Cash*: Cash, personal checks, cashier's check, traveler's check and money order. There will be a \$35.00 service charge on returned checks
- Credit Cards: Visa, MasterCard, Discovery, American Express and Debit Cards.
- Financing: Care Credit. As an added convenience to our patients, we provide assistance in obtaining a commercial loan to finance your surgery and/or procedures.

* There is a 5% cash discount incentive for all cosmetic surgeries. Payments by cash or cashier's check qualify to receive this discount.

Insurance and Cosmetic Surgery

Cosmetic surgery procedures are not covered under health insurance. Any attempt to obtain insurance payment for these services is fraudulent. Our office will not assist anyone attempting to defraud an insurance company or any other entity. Attempting to defraud an insurance company, this office or any other entity may result in civil and/or criminal penalties.

If the requirements for medical necessity, as outlined in your insurance plan/contract, are met we will submit a claim for surgery and/or procedures. Any claims submitted to your insurance carrier will carry charges for services, including office consultation, for which you are responsible.

Dr. Pastrick feels strongly that treatment decisions must ultimately be made by you, taking into account the information given during your consultation. While insurance coverage may be considered, it should not be the deciding factor in your treatment.

Dr. Pastrick and The Plastic Surgery Center are not participating with all insurance carriers. If we are not a provider with your insurance we will still, as a courtesy, assist you in receiving the maximum allowable benefits available under your insurance policy. In some cases we can file a claim on your behalf, provided you meet the criteria for medical necessity outlined by your insurance carrier. In most cases, we will receive payment from your insurance company which we can apply to credit on your account or refund your monies in full. You will be refunded only the amount your insurance company pays. However, you, not your insurance company, remain fully responsible for your entire bill. We will also, as a courtesy, try to outline your anticipated insurance coverage and "out of pocket expenses". This cost, along with the fee quote that you will receive on the day of your consultation, will allow us to estimate your bill.

Cosmetic Surgery

Cosmetic surgery is elective and not covered by your health insurance.

All patients consulting for cosmetic services will receive a complementary consultation. If, during the course of this consultation, it is determined that your desired procedure could be classified as medically necessary by your

insurance carrier you have the option to seek medical pre-approval for this service. If you request that our office seek pre-approval from your health insurance for any services your consultation status changes from cosmetic to insurance billable. As required by law, there will be a consultation fee applied to this appointment that may be submitted to your insurance company, but you remain legally responsible for the entire bill.

You will be provided with an all inclusive surgery quote on the day of your consultation. This fee is non-negotiable, and the quoted fee is effective for a period of six (6) months. Fees for cosmetic surgery are required prior to the surgical date as outlined in this financial policy.

To reserve a day for your surgery, a scheduling deposit of \$500.00 is required. This deposit is non-refundable and non-transferable. This deposit is applied to your actual surgery cost. If you reschedule or cancel your surgery for any reason your \$500.00 scheduling deposit will not be refunded or transferred to another date, service or person.

Situations sometimes arise that may make it necessary for you to postpone your surgery. Cancellation and rescheduling of surgery is disruptive to other patients, as well as our surgeon, surgical team and anesthesiologists.

If you cancel your surgery more than fourteen (14) days before your scheduled procedure, you will forfeit your \$500.00 scheduling deposit. You will also incur a \$500.00 cancellation fee to cover the cost of supplies ordered for your surgery and the cost of canceling the surgical team. If you wish to reschedule your surgery at this point you will be required to pay an additional \$500.00 scheduling deposit for the new surgical date. As before, this \$500.00 deposit is non-refundable and non-transferable.

If you cancel your surgery between seven (7) and fourteen (14) days before your scheduled procedure, you will forfeit half of your surgery prepayment.

If you cancel your surgery less than seven (7) days before your scheduled procedure, or fail to attend on your scheduled surgery time and date, you will forfeit the full amount of your surgery pre-payment.

There will be no refund for services already provided.

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 your results. Surgical revisions and/or other medical treatment or management of problems and/or complications may be required. These will result in additional charges for which you are responsible.

Patient Agreement

I have read and understand the above Financial Policy. I have had the opportunity to address questions about this Policy, and all my questions have been answered to my satisfaction. I agree to be bound by the terms of this Policy. I further agree that, if I default on any obligations under this Policy, I will be responsible for attorney fees, court costs, pre-judgment interest allowed by law, and expenses of collection.

Signed: _____
(Patient or Responsible Party)

Date: _____

Witness: _____
(Office Representative)

Date: _____