St. Croix Plastic Surgery & MediSpa
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Our Financial Policy

Thank you for choosing St. Croix Plastic Surgery & MediSpa as your health care specialist. We are committed to your treatment being successful. Toward that end, please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. **This form should be read, initialed on each page, signed on the last page and returned with the medical history page prior to treatment**.

Full Payment is due at the time of service unless other arrangements have been made. In order to reduce healthcare costs and to better serve you, we accept cash, checks, debit cards, Visa/Mastercard, and Discover cards. please be sure to have one of these forms of payment with you at the time of your office visit. If you do not have a form of payment on your person at your visit, we would be happy to re-schedule your appointment.

Insurance Information

Our practice accepts insurance from most major insurance companies. As a courtesy, we will file your claim to the respective insurance company. To avoid any misunderstandings regarding payment for professional services, St. Croix Plastic Surgery & MediSpa requests that you authorize all insurance company payments directly to our practice. If you choose not to do so, all charges will be due and payable by you at the time of service. You will be responsible for any portion of your bill which is denied, applied to deductible, considered a co-payment or co-insurance portion or is considered non-covered by your insurance plan. Working together we can resolve most insurance issues in a mutually acceptable and convenient manner.

Payment Policy

At the time of service, we will determine the portion of the bill for which you will be responsible. Prior to leaving, you will be responsible for paying your portion of the charge or pre-authorizing St. Croix Plastic Surgery & MediSpa to charge your debit card or major credit card for the portion not covered by insurance. In an effort to control health care costs, and to better serve our patients, it is St. Croix Plastic Surgery & MediSpa policy to minimize "billing" patients.

All self-pay patients will be required to pay at the time of service. Co-pays must be paid at the time service is rendered. These co-pays are a required part of your contract with your insurance carrier and increase the cost of billing unnecessarily if not paid at the time of service. Patients should receive a written notice from their insurance carrier when a claim is closed and payment is made to the practice. Our staff will apply this payment to your account upon receipt, but there may be a delay of 2 to 3 days in posting.

Refunds/Cancellation

Re-scheduling or cancellation of your surgery after it has been scheduled will result in loss of your deposit. Cancellation within two weeks of the surgery date results in one-half of the surgeon's fee being retained by St. Croix Plastic Surgery & MediSpa. Written notice of cancellation of your contract within three days of when you scheduled surgery will incur no penalty.

Cosmetic Procedures

Cosmetic procedures are defined as procedures whose goal it is to enhance normal appearance or reverse the visible signs of aging. Your physician is the final arbiter of what constitutes a cosmetic procedure. The charges for cosmetic surgery are composed of a surgeon's fee, anesthesia fee, facility fee, room rate, nursing fee, and preoperative testing fees. Follow-up office visits related to this procedure are included for up to 90 days after surgery. Additional costs related to services from the facility, other physicians (for example: pathology/pathologist services), and additional surgery which may be required would be your responsibility. We also require cosmetic patients to provide us with medical insurance information to have on file in the event medical treatment is required. A $500 deposit is required to schedule surgery. The surgeon's fee is due as follows: **One-half of the total surgeon's fee is due one month prior to surgery date and the balance is due two weeks prior to surgery for all cosmetic procedures.** After this time, no personal checks will be accepted, and payment will need to be made by cash, cashier's check, credit card, debit card or bank transfer of funds.

Billing Statement

The amount shown in the "Patient Responsible" column is your obligation and is due and payable upon receipt. If payment is late or prior payment arrangements have not been made, 1.5% monthly finance charge is assessed to all balances over 30 days past due. Accounts over 120 days without satisfactory payment will be turned over to a collection agency. Outstanding accounts cost both time and money; therefore, patients with delinquent accounts will be required

to make payment at the time of service. Several payment options are available for your convenience.

Billing Questions

Questions or concerns regarding your account or insurance claim should be directed to our office manager. Our practice firmly believes that a good doctor-patient relationship is based upon understanding and good communication. Business office employees are trained experts. They have been instructed to make every effort to clarify any misunderstandings you have concerning your balance and resolve your financial questions and concerns. Please notify us immediately if you feel an error appears on the statement or if you have any questions or concerns.

I understand that the responsibility for payment of services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 30 days. In the event of a default, (We) promise to pay legal interest on the indebtedness, together with such collection cost and reasonable attorney fees as may be required to effect collection of this note. **I have read the Financial Policy. I understand and agree to this Financial Policy**.

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Printed Name Signature of Responsible Party Date

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Printed Name Signature of Co-Responsible Party Date

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Printed Name Authorization for Assignment of Benefits Date