The Piazza Center
FOR PLASTIC SURGERY & ADVANCED SKIN CARE

FINANCIAL & CANCELLATION POLICY

Name: _____ DOB: _____

Please review the following policies and acknowledge receipt by your signature.

Charges

- Cosmetic office charges require reservation deposit at the time your appointment is booked.
- Cosmetic surgical charges require deposits and payment in full in advance of surgical procedures.
- Insurance based visits require copay and /or deductible in full at the time of your visit.
- Charges related to an auto accident or third-party injury require payment in full at each visit.

Appointment Reservations-Cancellations and No Shows

- Consultation appointments require a $100 reservation deposit at the time of booking.
- Injectable and skin care appointments require a credit card to be held on file.
- Injectable and skin care appointments cancelled with less than 24-hour notice or client is a No Show a reservation deposit of $50 will be charged.

Insurance Billing

- It is your responsibility to provide us with correct insurance information for billing purposes.
- Your insurance may require a deductible and/or coinsurance be paid prior to your surgery.
- All balances not paid by your insurance and deemed patient responsibility are due upon receipt of bill from The Piazza Center.
- No cosmetic or aesthetic based services will be billed to your insurance.
- It is your responsibility to respond to all requests for information you receive from your insurance company.

Overdue Accounts

- If your account has an amount due now, it is your responsibility to pay the balance timely.
- Accounts may be assessed a late fee if not paid within 30 days of receipt of statement.
- Accounts with a patient balance that are not paid within 90 days may be turned over to an outside collection agency. This action may affect your credit rating.
- Accounts referred to an outside collection agency may be charged the cost of collection fees and/or attorney fees.

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Authorization and Release

I have read and understand the information above. I understand that I am financially responsible for all charges not paid and/or discounted by my insurance company. I hereby assign to the physician, payments for medical services rendered to myself or my dependents.

****Signature**:** _____ **Date:** _____
Patient / Responsible party

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