RADY RAHBAN, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY

FINANCIAL AGREEMENT

Payment Options We Accept:

- ✓ Cash
- ✓ Cashier's Check (Made out to "Rady Rahban M.D.")
- ✓ Credit Cards (Visa, MasterCard, American Express, Discover)
- ✓ Financing: Available through Care Credit & Prosper Healthcare Lending.

***We DO NOT Accept Personal Checks.**

1. When you make a commitment to a surgery date, other patients lose the opportunity of scheduling that date, Dr. Rahban makes a commitment to you for this time, and arrangements are made with our anesthesiologist and surgery center staff.

   In order to reserve a date for your procedure, we required you to pay **a non-refundable/non-transferable deposit of 20% of the total quote.** **Payment in full is due 3 weeks prior to surgery** in order to confirm the reserved surgery slot. If full payment is not received 3 weeks pre-operatively, the reserved date may be forfeited to another individual. The following rules apply to the full payment excluding the non-refundable deposit.

   There is no penalty if you cancel or reschedule more than 30 days before surgery and have paid in full (excluding the deposit). If you cancel within less than 30 days before surgery, the deposit is forfeited. If you reschedule the surgery date within less than 30 days of surgery, the original deposit is forfeited, and you therefore will be required to pay another non-refundable and non-transferable 20% deposit to reserve another surgery date.

   Patient Initials _____

2. In the event of a revision or secondary surgery, you understand that you are at a minimum responsible for all OR and anesthesia fees, in addition to the cost of any implants. Dr. Rahban's surgical fees, which are assessed on a case to case basis, may be waived or discounted. All of these fees will be collected 3 weeks prior to the procedure, on the date of the pre-op appointment.

   Patient Initials _____

3. You understand that any tissue/specimen removed during surgery will be sent to pathology for evaluation and that you are therefore responsible for these fees.

   Patient Initials _____

4. In the event external collection services become necessary to obtain an outstanding balance, you will pay all collection agency fees, returned check fees and attorney fees, as well as court costs associated with such collections.

   Patient Initials _____

5. You acknowledge and agree that you have paid, or will pay for any services, surgery or products in full and by signing below you acknowledge and agree that you will not stop payment on credit cards, debit cards or checks after services have been rendered.

Patient Initials _____

6. Should any type of credit card or payment dispute be initiated, despite the above initialed clause, you agree to waive your HIPAA rights in matters of dispute of payments.

Patient Initials _____

7. Dr. Rahban is not in network with any insurance companies. You are responsible for all of your medical bills. In order to help you when you desire to submit a claim to your insurance on your own, we will do our best to assist by providing an invoice for you to use when submitting your claim. This invoice is NOT a superbill and will not contain any procedure or diagnostic codes, as they are constantly changing, and our office does not use CPT coding.

Patient Initials _____

I have read all the above financial and revision policy and agree to abide by it.

_____

PRINT PATIENT NAME DATE

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PATIENT SIGNATURE WITNESS