ALABAMA
PLASTIC AND RECONSTRUCTIVE SURGERY

Blake S. Raggio, MD
Facial Plastic Surgery

Cosmetic Surgery Cancellation Policy & Financial Agreement

Please read and **initial** the following statements outlining our payment and cancellation policy, and your expected financial responsibilities:

1. SCHEDULING DEPOSIT: A non-refundable deposit of **$500.00** is required to hold a date for surgery; it will be applied toward the balance of your account. Until a deposit is made, there is no guarantee of a date being held for you. While the fee is non-refundable, if re-scheduling is necessary, this fee will apply towards the balance of the account.

2. COSMETIC QUOTE AND PAYMENT: The quoted cosmetic invoice remains valid for 90 days after the initial quote. Any remaining cosmetic procedure fees must be paid in full **no later than fourteen (14) days prior** to the date of surgery.

3. INSURANCE PAYMENT: You are financially responsible for any amounts due from you for the medically necessary procedures listed above, including but not limited to co-payment, co-insurance or deductible. Information received from your insurance company is not a guarantee of payment. Final determination of benefits is made when your insurance company receives our claim. It is your responsibility to become familiar with your insurance requirements and policies.

4. CANCELLATION / RESCHEDULING POLICY: The cancellation or rescheduling of surgery **before thirty (30) days** will result in no additional penalty. Once a surgical date is booked, any subsequent cancellations or alterations of the date **within thirty (30) days** of the scheduled surgery date will be subject to a cancellation/rescheduling fee equal to the deposit amount. Cancellations or alterations of the date **within fourteen (14) days** of the scheduled surgery date will be subject to a cancellation/rescheduling fee equal to 25% of the associated cosmetic fees paid. Cancellations or alterations of the date **within 72 hours** of the scheduled surgery date will be subject to a cancellation/rescheduling fee equal 50% of the associated cosmetic fees paid. Appeals made to the above policy will be reviewed on a case-by-case basis by Dr. Raggio and the associated medical staff and administration (office, surgery center, hospital, etc.)

5. ADDING ADDITIONAL PROCEDURES: If you choose to add any additional cosmetic procedures to your already scheduled surgery, you have the option to do so up to **seven (7) days prior** to your surgery date with any added costs payable at that time

6. FINANCIAL RESPONSIBILITIES: I understand and agree that I am electing to receive cosmetic services as described above in the cosmetic procedure section of this acknowledgement form. I understand cosmetic surgery is elective and not considered a medical necessity. I also understand and agree to accept full financial responsibility for the costs associated with the above described cosmetic procedure which includes fees charged by your doctor, anesthesia, and the facility to include the cost of surgical supplies, anesthesia, laboratory tests, and other possible outpatient or hospital charges, depending on where the surgery is performed. I agree that insurance will only be billed for the services outlined in the medically necessary portion of this acknowledgment and that insurance will not be billed for cosmetic procedures described. I further acknowledge that I accept full financial responsibility for any co-insurance, co-payment and/or deductible associated with the medically necessary procedures described above and other charges not covered by the cosmetic fee. I also acknowledge that the cancellation policy as outlined above is reasonable and understand that the cancellation of this procedure will result in a disruption to the operating room schedule and subsequently a loss of revenue and additional incurred operation and administrative costs to the provider. Additional costs may occur should complications develop from the surgery. Secondary surgery or hospital day-surgery charges involved with revision surgery are also your responsibility.

I understand my financial responsibilities and that cancellation fees will be levied should I reschedule or cancel a surgical procedure without sufficient notice as described above. I acknowledge I have read the above and have been provided with ample opportunity to ask questions and seek clarification.

Signature of Patient / Representative	*Printed Name*	*Date/time*
Signature of Witness	*Printed Name*	*Date/time*

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