AUSTIN PLASTIC SURGERY INSTITUTE
& SKIN CARE CLINIC

FINANCIAL POLICY | DR. JUSTIN BOOTH

There is a $50 consultation fee that is applied to any surgery scheduled with Dr. Justin Booth. Any quote given today is valid from the day of the initial consultation to 90 days after the initial consultation.

SCHEDULING/PAYMENTS: To schedule and save your date for surgery, a non-refundable 20% deposit of the total cost of the procedure will be required to schedule your surgery. Total payment is due in full two weeks prior to the procedure for all forms of payment.

If scheduling your surgery less than 2 weeks prior to your surgery date, full payment must be made at the time of scheduling.

If paying by check, a certified bank check will be required.

Credit card payments will require a copy of your driver's license to be present in your patient file.

CANCELLATIONS: Full payment is required 2 weeks prior to the surgery. If payment is not received, your surgery will be cancelled unless arrangements have been made.

DISPUTES/REFUNDS: Any disputes with the credit card company used for payment after the procedure is completed, patients acknowledge by signing below that they will waive their right to portions of the HIPAA policies and that portions of their medical records will be used to clarify the dispute with the credit card company. This can include all documents that authorized the procedure by you the patient.

Please note that surgeons' fees are based on the procedure(s) performed. Along with our fees, this quote includes facility and anesthesia fees which are based on our estimate of time needed to perform the surgery. If the scheduled time is exceeded, there may be additional charges from the facility and the anesthesia group that are billed to you following the surgery. If the procedure takes less time than anticipated, a refund may be given. In either case, there will be no adjustments to our fee.

COSMETIC WAIVER: I understand that this surgery is cosmetic in nature and is not medically necessary. Therefore, it is not reimbursable by any insurance payor, and I am financially responsible. I have been advised that if I want a predetermination to assess eligibility for insurance coverage for this surgery that this must be done in advance of the surgery. By signing this waiver, I agree the surgery is cosmetic in nature and no insurances will be billed. I am fully responsible for payment.

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Signature: _____

Print Name: _____

Date: _____