THOMAS TREY SANDS M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY

Patient's Name: Patient #:
Scheduled Surgery Date: Date of Estimate:

PROCEDURE	TOTALS	These fees do not include choice of overnight care.
Dr. Sand's Fee		Overnight Stay at Hospital Per Night
		ALL FEES ARE TO BE PAID SEPARATEDLY.
Facility Fees		
DISCOUNTED PRICE		

I understand that I am responsible for the total non-covered procedure listed above in the amount of ($_____) (**cashiers check, credit card or cash**) 7 days prior to the procedure. **No Personal Checks, please. Fees include Surgeon's Fee, Operating Room, and Anesthesia. Additional charges may be incurred should blood test, EKG, or special testing be required for my safety as well as pathology fees.** Cancellation of surgery requires a 3-working day notice**, any services performed will be charged for those surgeries scheduled and cancelled in less than 3 working days notice.** The price estimate is good for six (6) months from the above date. There is a scheduling deposit of $300.00 that is required to reserve your date of surgery. This Deposit is non-refundable. The **facility fees and anesthesia fees are only estimates since the actual surgery and anesthesia time cannot be predicted to the minute before hand**. All fees are due on your pre operative visit, which is on _____. Fees charged by Dr. Sands, the facility and anesthesia are separate charges, and will require separate payments respectively.

Date

Signature

I also understand that this is an estimate only. Unnecessary delays that occur due to failure to locate a responsible adult at the time that the patient is medically ready for discharge to home will result in an additional fee (see above). Surgery is unpredictable and unanticipated findings or delays may result in additional charges should I require additional care for my safety. I may require admission to the hospital if I am not fully recovered for discharge and this will result in additional charges. **Secondary revision**

surgery will also result in additional charges. If your surgical procedure is being pre-certified and you choose to schedule your surgery prior to having the authorization; we will not file with your insurance afterwards, even if surgery is approved. If you are having a procedure that is covered by insurance you will be responsible for your deductible and or co pay.

_____

_____

Date Signature

Date Witness

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