

FINANCIAL POLICIES
For
COSMETIC AND NON-INSURANCE COVERED SURGERY

As patients approach surgery, they frequently have questions about the cost of surgery and payment options. We hope the following information will be helpful. Please read it carefully and feel free to ask us any questions should they arise.

Cosmetic Surgery Payment Options

The cost for cosmetic surgery is based on three factors: (1) the type of surgery (surgical fee), (2) anesthesia fee and (3) OR/surgery center (facility) fee. The first is a fixed fee; the latter two are time dependent. Your estimate of charges includes the likely time it will take to perform the surgery. There are circumstances in which your surgery may last longer than the anticipated time. You, the patient, will be responsible for the additional charges from the facility and anesthetist. The surgical fee will not change regardless of time.

Payment in full of Dr. Andochick's surgical fee is required ***two weeks*** prior to your surgery. We provide a number of payment options which may be used individually or combined according to your wishes.

CASH OR CHECK:

Personal check, cashier's check, or cash.

CREDIT CARDS:

Visa, Master Card, Discover or American Express.

OPTIONAL FINANCING PLANS: Financing is available for cosmetic and reconstructive plastic surgery. We will be happy to assist you with applying for financing should you so desire.

Cancellation Policy

We understand that a situation may arise that could force you to cancel or postpone your cosmetic surgery. Please understand that such changes affect not only your surgeon but other patients as well. Should you find it necessary to cancel your surgery within 48 hours of the scheduled procedure, you will be entitled to a full refund minus a \$500.00 cancellation fee.

Prior to your surgery, please discuss all arrangements regarding payment of your account with us. If you need assistance with any financial matters our office will be happy to assist you.

I have read the above and have a full understanding of my financial responsibility with the office of ANDOCHICK CENTER FOR COSMETIC SURGERY.

PATIENT SIGNATURE_____ DATE _____