SARASOTA PLASTIC SURGERY, INC. FINANCIAL AGREEMENT

Cancellation Policy

- Patients that no show/do not confirm their appointment or cancel without 24-hour advance notice will be charged $150.00 for surgical consultations and $50.00 for non-surgical appointments and/or treatments.
- Habitually missing or changing appointments is grounds for dismissal from the practice. This applies to surgeon appointments and skin care appointments.
- *As a courtesy, we attempt to remind patients by phone of their scheduled appointments. However, it is the patient's responsibility to keep his/her appointments whether or not a reminder call is received.*

Clinical Services

- All services must be paid for at the time of service.
- Skin care products may be returned or replaced within 14 days of purchase.
- Gift certificates must be present at the time of service.

Surgical Fees

- Payment is due in full 4 weeks (28 days) prior to the scheduled surgery date. We accept Visa, Mastercard, Discover, American Express, CareCredit/Alphaeon, and Cashier Checks/Personal Checks. *WE DO NOT ACCEPT CREDIT CARD CHECKS.* All personal checks will be processed through TeleCheck as an electronic transfer. **If you are paying with a Debit Card, please verify with the bank your daily limit policy.**
- If your surgery is cancelled or postponed 4 weeks (28 days) prior to surgery, your fees will be refunded. If your surgery is cancelled within the 4 weeks (28 days), you will be charged a $500.00 administrative fee and a fee for any services provided; such as laboratory work or skin care services. If your surgery is cancelled within fourteen (14) business days of your surgical date, an additional administrative fee of 25% of your total charges will be withheld from your refund. If your surgery is cancelled within 3 business days of the procedure, you will be charged 50% of the total charges.
- *All tissue that is removed during surgery will be sent to Pathology and the patient will be responsible for these charges. It is the patient's responsibility to notify us regarding where their insurance prefers pathology to be sent to avoid out-of-network charges.*
- MEDICARE PATIENT'S: Medicare will not process any other provider claims (i.e., Coral Anesthesia/SaraPath) without receiving a claim from your surgeon. "Cosmetic and/or Non-Covered Medicare Services", the patient is responsible for ALL fees associated with their surgery. Please note Dr. Mobley, Dr. Engel, Dr. Derby and Dr. Baratta do not participate with Medicare: therefore, ALL fees associated with surgery are the patient's responsibility.
- We do not accept health insurance, obtain prior authorizations, submit or file insurance claims, or communicate with insurance companies on your behalf.
- If postponing a surgery more than two (2) times, a 50% deposit will be required to hold a new surgical date and will be forfeited if date needs to be changed. In addition, such changes could result in dismissal from our practice at the surgeon's discretion.
- The services that are performed and paid for using a credit card or debit card are not eligible for credit card challenge. By signing this form, you are agreeing you will not challenge credit card payments once a service has been rendered. The practice encourages a complete post-op care and follow-up interaction to address any issues that might arise following services rendered.
- Complimentary Botox® Cosmetic or Dysport® "Touch Up" appointments will only be honored between week two (2) and four (4) post initial injection. After four (4) weeks standard fees will apply.
- **The policies listed above will be applied in every situation.**

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guarantee the payment of all amounts when and as due.

A photocopy of this agreement shall be considered effective and valid as the original.

DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS. MY SIGNATURE BELOW INDICATES I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS STATED IN THIS FINANCIAL AGREEMENT/CANCELLATION POLICY.

Patient **Date**

Witness **Date** **REV 7/28/26**