FINANCIAL AGREEMENT

This agreement made and entered into to be effective as of the date recorded below between Chattahoochee Plastic Surgery, P.C., herein to as CPS, and Patient, or Responsible Party if not the Patient, herein referred to as Patient, named below. By executing this agreement, Patient agrees to pay for all services provided by CPS.

Monthly Statement: If Patient has a balance on his/her account, he will receive a monthly statement. The statement will show any previous balance due, any new charges to Patient's account, and any payments or credits applied during the month.

Payments: Unless CPS approves other arrangements in writing, the Patient's balance is due when the statement is issued and is considered past due within 30 days of the statement date.

Cosmetic Surgery Deposit & Cancellation Policy: Patients are required to pay a $400 deposit fee to be placed on the surgery schedule; the remaining balance is due two weeks prior to surgery date. If patient cancels within fourteen (14) business days of surgery, a full refund including deposit will be given. If surgery is rescheduled, the deposit will be forwarded toward surgical fees of new surgery date. If surgery is not rescheduled within six months, the deposit will be forwarded toward processing fees and non-refundable. If patient cancels less than ten (10) business days a partial refund, excluding a $400 surgical & processing fee, will be given.

Past Due Accounts: CPS will take all of the necessary steps allowed by law to collect on past due accounts. If Patient's account becomes past due and Patient does not contact CPS to set up a payment plan, a service charge, which will be 10% of the account balance, will be added to the account. If CPS is forced to refer the account to an outside collection agency, a service charge, which will be 30% of the balance, will be added to the account.

Returned Checks: CPS will charge a fee in the amount of $25 for each check returned by the Patient's bank.

Transferring / Receiving of Records: Patient will need to make a written request to have copies of their records sent to another doctor or organization. This includes all relevant information concerning patient, including payment history. If Patient requests that records be sent to CPS from another doctor, Patient authorizes CPS to receive all relevant information concerning patient, including payment history.

Insurance: Insurance coverage is a contract between Patient and the insurance carrier. Any co-payment required by an insurance company must be paid at the time of service. Patient will also be required to pay deductibles if not met at time of service. For any procedure not covered by insurance, such as cosmetic procedures, patient agrees to pay the full consultation fee at the time of service. Every patient is responsible for knowing the specific requirements of their insurance companies. CPS will bill Patient's primary insurance carrier as a courtesy, however it is the insurance carrier that makes the final determination of eligibility and payment. To assist you in making sure all insurance requirements are met, please let us know if you are required to have any of the following:

1. A referral / permission slip from you Primary Car Physician (PCP) to see our doctor.
2. The required use of a particular hospital ____________________________________.
3. The required use of a particular laboratory __________________________________.
4. Prior authorization / Pre Certification for out patient surgeries or inpatient hospitalization.

It is the Patient's responsibility to make sure all insurance requirements are fulfilled. It is also the Patient's responsibility to notify CPS of any changes in their insurance coverage.

By signing this agreement, Patient agrees to all of the terms and conditions contained herein and the agreement will be in full force and effect. I authorize the use of my signature on all insurance submissions. CPS may use my health care information and may disclose such information to my insurance carrier and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

Signature
(Responsible Party): ____

Responsible Party
(If not the patient): ____

Patient's Name: ____