



3734 West Chester Pike
Newtown Square, PA 19073
P 610.356.6100
F 610.356.6108

Financial Policies:

- Elective cosmetic procedures are not covered by insurance.
- The first cosmetic consultation is complimentary.
- There is a fee for insurance consultations. A bill for the consultation will be submitted to your insurance company.
- If we submit your surgery to insurance, you are responsible for your deductible & co-pays (payable to our office).

Scheduling Surgery:

- A 20% non-refundable deposit is required to book your surgery (this fee holds your date & time of surgery).
- The balance is due in full 2 weeks prior to the date of surgery.
- We provide a number of payment options, which may be used individually, or combined (Cash, Check, Visa, MC, Discover, Amex, and CareCredit).

Cancellation/Rescheduling Policy:

- We understand that a situation may arise that could force you to postpone your surgery. Please understand that such changes affect not only your surgeon but other patients as well. The surgeon's time, as well as that of the operating room staff, is valuable and we request your courtesy and concern.
- You may reschedule your surgery once at no charge with at least 14 days notice. Your deposit will be applied to your rescheduled date.
- Should you need to reschedule your surgery again, there will be an additional \$500 fee to do so.
- If you cancel your surgery within 14 days prior to surgery, the 20% deposit is nonrefundable. We will refund any additional payments that have been paid.

Other Charges:

- Some surgeries are performed in the hospital or outpatient surgery centers. Please be aware that the hospital and anesthesia fees are separate expenses. You will be responsible for making payments separately for these fees.
- If your surgery is taking place at the Surgery Center, the operating room and anesthesia fees must be paid in full 2 weeks prior to the date of surgery.
- If you require a revisionary procedure, the operating room fee and anesthesia fee would be your responsibility. There may be an additional fee for the surgeon depending on the revision that is necessary.

Agreement:

I have read thoroughly, understand and agree to the above policies and conditions.

Signature: _____

Date: ___/___/___