Treatment policy

Our treatment policy is as follows to assure that you have the best surgical experience possible and are fully informed throughout our relationship.

- A **$1,000 non-refundable** deposit is collected when a surgery date is selected. For minor procedures, full payment is due at the time of booking.
- Unfortunately, **we do not accept** personal checks as a form of payment. We apologize for any inconvenience this may cause. We will accept cashier's checks or any check drafted from a financial institution.
- Rescheduling any procedure results in a $500 rescheduling fee. Rescheduling two (2) weeks before a scheduled date results in a $1,000 rescheduling fee.
- Final balance is due two (2) weeks prior to surgery. If payment is not received, surgery is subject to cancellation.
- Upon cancellation, if made within two (2) weeks of scheduled date, 25% of treatment fee will be non-refundable. Upon same day cancellations, at no fault of patient, refunds may be issued at practice manager's discretion.
- If required, it is the patient's responsibility to perform requested pre-operative tests three (3) months prior to surgery, or when instructed. Patients must ensure results are submitted in order to avoid surgery cancellation.
- Prescribed medications and all pre-operative tests are **additional costs.** Some patients may require pathology or radiology; these costs are NOT covered by **IDEAL PLASTIC SURGERY** and are the patient's responsibility.
- If instructed to lose weight in order to perform a safe surgery and deliver satisfactory results, you acknowledge that by not losing the suggested weight, you are compromising your health and results. If weight goal is not met, procedures may be canceled or rescheduled at the discretion of your surgeon. Cancellation and rescheduling fees will apply.
- I acknowledge that if I am a smoker, I need to suspend tobacco use and the use of products containing nicotine six (6) weeks prior to surgery and four (4) weeks after. I understand that if I do not comply, I am at greater risk for significant surgical complications such as skin dying, delayed healing, and additional scarring. I acknowledge that nicotine tests are routinely performed on the day of surgery. Should I test positive, **IDEAL PLASTIC SURGERY** reserves the right to cancel my procedure. Refunds will not be given in this instance.
- I understand that although **good results are expected,** there is no guarantee or warranty expressed or implied on the results that may be obtained. It is important that all patients seeking to undergo elective surgery have realistic expectations that focus on improvement rather than perfection. Complications or less than satisfactory results are sometimes unavoidable and may require additional surgery.
- It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment. Services that are performed and are paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. By signing below, I am irrevocably consenting to allow the use and disclose my protected health information to any credit card entity, bank, or financing company when they request such information to process an account and assist with payment.
- Ideal Plastic Surgery is a private practice; therefore, any service or procedure performed here cannot be processed through insurance; we will not provide itemized billing or become involved in any insurance claims.
- By signing below, I certify that I have disclosed my medical and surgical history to the best of my knowledge.

We routinely use deidentified patient images for marketing purposes and no financial compensation is given to patients for this purpose.

I have read and understand the treatment policy provided by IDEAL PLASTIC SURGERY and accept responsibility for the payment of any fees associated with my care for ANY upcoming or future procedures.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____