CHARLESTON OCULOFACIAL
PLASTIC SURGERY

PATIENT COSMETIC SURGICAL AGREEMENT

Patient Name: _____

Patient Responsibilities:

- I have listed all known allergies, medications I am using, prior operations, and illnesses/medical conditions on my medical history form.
- I agree to keep Charleston Oculofacial Plastic Surgery informed of my permanent address and phone so that I may be contacted regarding any late findings or developments.
- I understand that cosmetic surgery fees are not billable to insurance, nor will they be submitted to insurance by Charleston Oculofacial Plastic Surgery.

Payment Policies:

- A $1000 scheduling deposit is due at the time a surgery date is chosen and a commitment is made to you to reserve this time. This deposit will be credited towards the surgeon fees. This deposit is refundable until 14 days prior to the scheduled date of surgery.
- Surgeon fees are payable to "Charleston Oculoplastics, LLC" and due in full 21 days prior to surgery. VISA, MC, AMEX, personal or cashier's check, or money orders are accepted.
- Fees are refundable in full up to 14 days prior to surgery. This balance is 50% refundable if surgery is cancelled or rescheduled by the patient between 8-14 days prior to surgery. There is no refund for cancellations or reschedule 7 days or less prior to surgery date.
- If payment was made with credit card and a refund is issued, there will be a 3% credit card processing fee on the refund.

Extra Expenses:

- I understand that the fees quoted to me are solely for the anticipated procedure. I understand there is a very small possibility that there might be additional expenses due to complication. I agree that I am solely responsible if there are any such additional expenses, such as ER visit, hospitalization, etc.
- I understand that there is no guarantee that I will be 100% satisfied with the results of the procedure. However, if, after healing is essentially complete, Dr. Patel and I both agree that the procedure did not substantially accomplish the results which could be reasonably expected under all of the circumstances, and if we both agree that a surgical revision could be expected to **significantly** improve the results of the initial procedure, then Dr. Patel agrees to provide the revision in the office, if able, for a **reduced supplies fee of $500**. I understand certain revisions may need to be performed at the surgery center in which case, I am responsible for any facility fees and anesthesia fees. This agreed upon revision must be performed within one year following the original procedure.
- I understand that I am responsible for the costs of all lab tests, prescriptions, imaging, etc.

_____

Patient Signature

_____

Date