



## PAYMENT POLICY

Payment is due in full at the time of service for all office visits, ancillary services and product. We accept cash, check, VISA, MasterCard, American Express and Discover for your convenience. Financing is available through CapitalOne healthcare finance.

The Petroff Center has a 30 day exchange policy for all product purchases.

### **Insurance**

Insurance billing is provided. It is your responsibility to pay any copays or obtain any necessary referrals prior to your appointment, as directed by your plan. In order to provide insurance billing you must supply complete and accurate insurance information.

### **Surgical Payments**

Payments for all elective cosmetic surgeries are collected in full two-weeks prior to the procedure date.

### **Anesthesia Payments**

All elective anesthesia services provided by Jeannie C. Lee, CRNA or On-Site Anesthesia Services, Inc. are due and payable on the date of service. For insurance cases please inquire within.

### **Lab Fees/Prescriptions/Surgical Pathology**

All lab/EKG fees, surgical pathology and prescriptions are the responsibility of the patient. In most cases, your insurance will cover these services.

### **Payment Plans**

Monthly payment plans are available for consideration on any unpaid balances by insurance. Monthly payment plans require signature and completion of standard budget agreement.

### **Late Fees**

A \$5.00 monthly service charge will be applied to any unpaid balances not paid in full within 90 days from the date of service.

### **Canceled Checks**

A \$35.00 NSF charge will be applied to my account for any checks returned for insufficient funds.

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. All accounts assigned to collections will be charged a \$50.00 collection fee. I hereby authorize the doctor to release information necessary to secure the payment of benefits. I authorize payment of insurance benefits directly to the Petroff Center. I authorize the use of this signature on all insurance submissions.

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Signature of Patient (for patients over the age of 18)

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Date

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Signature of Guarantor or Legal Guardian (for patients under the age of 23)