

**Kelamis Plastic Surgery Office Policies and Financial Agreement**

**Patient Name:** \_\_\_\_\_

Welcome to our practice. Please take a few moments to review our office policies. If you have questions, please do not hesitate to ask. If you should have changes in your personal data including medical history or insurance coverage, please ensure we are notified. In addition, be certain we have a current copy of your insurance card.

Payment is due at the time of service unless arrangements have been previously made. Please be aware there is a \$30 returned check fee. If your check is returned, payments will need to be made by credit card, Care Credit and cash for all services.

**Cosmetic/Self-Pay Payment Policy for Surgical Procedures:**

- A consultation fee of \$75 will be due at the time of service.
- For cosmetic surgical procedures, a \$500 non-refundable deposit is required to schedule the surgery. This will be applied to the remaining balance which is due in full 2 weeks prior to the scheduled surgery. If the cosmetic surgical procedure fewer than 2 weeks before the surgery date, the balance is due in full at the time of scheduling. Payments not received by the deadline will result in cancellation of the scheduled procedure.
- If you cancel OR RESCHEDULE your cosmetic surgical procedure within 5 business days or less of the scheduled procedure date, this may result in you being charged 25% of the quoted amount.

**Insurance Policy Payment:**

- Please be certain we have a current copy of your insurance card.
- If Dr. Kelamis anticipates your procedure will be considered for insurance coverage, your co-payment will be required at the time of the consultation.
- If we have been provided with proper insurance information we will gladly submit your claim for services to your primary and secondary insurance companies (if applicable).
- You will be responsible for all copayments and deductibles.
- Some minor surgical procedures may be performed in clinic if desired. Professional services will be billed to your insurance company.
- Through Ozark Coding Alliance, we will provide you with an estimated payment amount before your surgery. Please understand this is only an estimate and you may still owe a balance after the claim is filed.
- It is your responsibility to understand your insurance coverage. Please use the proposed treatment plan as a reference when contacting your insurance carrier. If your insurance carrier denies any part of your claim, you will be responsible for the balance in full.

Please sign below as an indication that you have read, understand and accept these office policies.

\_\_\_\_\_  
Patient or Responsible Party's Signature

\_\_\_\_\_  
Date