



South Coast Outpatient Surgery Center
Anesthesia Associates

PATIENT FINANCIAL POLICY & AGREEMENT

Patient has requested and received an estimated price quotation for surgical procedure(s) to be performed by a CosmetiCare plastic surgeon.

SURGERY DEPOSIT

Should patient choose to proceed with surgery, a \$500.00 (five hundred dollars) NON REFUNDABLE deposit is required to reserve your surgery date. This deposit is credited towards the surgery fee balance due, as illustrated in the estimated price quotation of your requested surgical procedure(s). Cancellation of your reserved surgical date regardless of the notice given will result in the forfeiture of the \$500.00 NON REFUNDABLE deposit.

CANCELLATION POLICY

Upon giving a surgery deposit, you understand that a surgery date has been reserved specifically for you, the patient. This involves the commitment of your surgeon, anesthesiologist, surgery center, recovery room team, surgical team and necessary surgery equipment & supplies to be reserved for the time period required to perform your surgical procedure(s) on the surgery date you (the patient) have chosen to reserve.

As such, you (the patient) acknowledge that any cancellation of the reserved surgery date less than 7 (seven) days prior to scheduled surgery date, is an insufficient period of time within which CosmetiCare, South Coast Outpatient Surgery Center, & Anesthesia Associates can re-schedule or schedule another patient for surgery to fill the cancelled time slot.

\*Therefore, any cancellation or postponement initiated by the patient with less than 7 (seven) days notice prior to the date of surgery will result in patient forfeiting all fees, including the \$500.00 deposit.

\*If cancellation or postponement of scheduled surgery date is initiated by the patient with at least 7 (seven) days notice prior to date of surgery, 50% (fifty percent) of surgery fees paid (excluding the \$500.00 deposit) will be refunded from CosmetiCare, South Coast Outpatient Surgery Center, and Anesthesia Associates.

NOTE: If surgical fees paid in full included the cost of implants, a refund for the implant cost will be issued to patient within 30 days.

PAYMENT SCHEDULE

After CosmetiCare has received your surgery deposit, all balances due for the surgical procedure(s) must be PAID IN FULL no later than your scheduled Pre-Operative appointment. \*\*FAILURE TO PAY ALL BALANCES DUE UPON YOUR PREOPERATIVE APPOINTMENT WILL RESULT IN CANCELLATION OR RESCHEDULING OF YOUR RESERVED SURGERY DATE.

ACCEPTABLE METHODS OF PAYMENT

We accept Cash, Cashier's Checks, Money Orders, and Major Credit Cards. Personal Checks and Debit Cards are NOT accepted for balances due.

I HAVE READ AND UNDERSTAND THE OUTLINED PATIENT FINANCIAL POLICY AGREEMENT PROVIDED BY COSMETICARE, SOUTH COAST OUTPATIENT SURGERY CENTER, AND ANESTHESIA ASSOCIATES.

PATIENT SIGNATURE
(Parent or guardian signature if patient is a minor)

DATE

WITNESS

DATE



## Health Care Disclosure Notification

Dear Patient:

Effective April 14, 2003, the Federal Health Privacy Rule must be implemented and we must inform our patients of their rights under this law.

While we have always made every effort to keep all your information confidential, we are now required to inform you of those persons or entities who may have access to your personal and health care information.

1. Employees of CosmetiCare and South Coast Outpatient Surgery Center (limited by job classification)
2. Physicians associated with your treatment or surgical procedure
3. Outside physicians or pathologist who would examine tissue removed
4. Anesthesiologist associated with the Surgery Center
5. Any physician or hospital to whom you are referred by our staff physicians
6. Any independent contractor working with CosmetiCare, i.e. consultants and aestheticians
7. Any independent contractor working with South Coast Outpatient Surgery Center, i.e. , registered and licensed vocational nurses and technologists.
8. Your health insurance provider
9. Designated family members or friends (post surgical)
10. Accrediting agencies
11. Medical staff committees for the purpose of quality assessment and peer review
12. Licensing agencies in response to inquiries
13. Issuance of a subpoena and upon verification of authorization
14. Research - patients who are participating in a clinical study

ALL PATIENTS WILL BE REQUESTED TO SIGN A CONSENT PRIOR TO TREATMENT.

### Patient's Rights

1. Patient has the right not to sign consent. However, this would necessitate the physician to refuse treatment.
2. A patient has the right to revoke the consent after receiving treatment.
3. Patient has the right to request restrictions and request confidential communication.
4. Patient has the right to examine and review his or her health information upon written request. This request will be honored within five (5) working days.
5. Patient has the right to request a copy of his or her health information upon written request. The copy will be completed within 15 days of receiving request at a cost to the patient of \$ 0.25 per page.
6. Patients have the right to request an amendment to their health information and, if accepted, this will become a part of the complete medical record. Information and procedure to be followed can be received by contacting April Lee at extension 255.
7. Patients who feel their privacy with regards to personal or health care information has been compromised may contact:
  - a. April Lee, in this office, at extension 255
  - b. Department of Health and Human Services
  - c. Office of Civil Rights

NOTICE: By signing this notification you are agreeing that you have been notified of the Federal Health Privacy Rule now in effect.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Signature: Patient or Patient's Representative

\_\_\_\_\_  
Date



## CONSENT FOR THE DICLOSURE OF HEALTH AND PERSONAL INFORMATION

You have already received our Disclosure Notification, which made you aware of the persons and entities whom could possibly have access to your medical information for the purposes of treatment, payment, and health care operations.

As stated in the Notification, you have the right to request restrictions or revoke your consent. If you have any further questions or need clarification, please discuss with a member of our staff.

I consent for the use of my medical/personal information to be used for the purposes outlined in the Disclosure Notification.

I have restrictions:  Yes  No \_\_\_\_\_ Initial

Please list any restrictions below:

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Restrictions Approved by Provider:  Yes  No \_\_\_\_\_ Initial

I have read and understand the foregoing Consent for Disclosure.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Signature: Patient or Patient's Representative

\_\_\_\_\_  
Date