THE CENTER FOR AESTHETIC FACIAL SURGERY
MICHAEL R. MENACHOF, M.D.

FINANCIAL POLICY & PRIVACY PATIENT AGREEMENT

Thank you for choosing The Center for Aesthetic Facial Surgery. We are committed to giving you the best care possible, and we want you to completely understand our financial and privacy policies. The following is a statement of our Financial Policy and our Privacy Policy, which **we require you to read and sign prior to any treatment.**

- Payment is due at time of service or if surgery is scheduled, payment must be made two weeks prior to the surgery. We accept Visa, MasterCard, American Express, Discover, cash and checks. Capital One Financing is also available for surgery. Please note: if paying by check, you understand and authorize all dishonored checks plus a processing fee with applicable taxes to be electronically debited from your account.
- A **CANCELLATION FEE** of **$35** will be charged on all missed appointments. 24-Hour notice is required to cancel an upcoming appointment—less than 24 –hour notice will be charged as a missed appointment. Due to the office being closed on weekends—Monday appointments must be cancelled no later than close-of-business on the Friday prior to your Monday appointment.
- Only after exhausting our internal attempts for payment, we will send a delinquent account to our collection agency. Should this happen, you will be responsible for all costs incurred in collecting the account. You will be required to pay your account in full before scheduling another appointment if your account is in collections.
- We respect your right to keep your treatment private and confidential.
- No photos will be used of you without written consent.
- You have the right to request that we restrict our disclosure to only certain individuals involved in your care or the payment for your care, such as family members and friends.

We reserve the right to revise or amend this Notice of Privacy Patient Agreement. Any revision or amendment to this notice will be effective for all records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future.

I have read and understand the FINANCIAL POLICY AND PRIVACY PATIENT AGREEMENT of The Center For Aesthetic Facial Surgery, and I agree to be bound by its terms.

____________________________________ ____________________
Name of Patient (PLEASE PRINT) Date

____
Signature of Patient (or Responsible Party if minor)