visionary eye care

Cosmetic Procedure Financial Policy

Dr. Hidaji and his staff consider it a privilege that you have chosen us to perform your procedure. We strongly believe in informing you of all the medical aspects of your procedure as well as our financial policy.

Your surgical fees are quoted in writing at the end of your consultation. This quotation will be honored for six months and will generally include the surgeon's fee, operating room costs, and other fees for a routine, uncomplicated procedure. The quoted fee will include all of the pre- and post-operative visits. The quoted surgical fee does NOT include any pre-operative services you may require, such as x-rays, blood tests, pre- and post-operative medications, labs or evaluation by another physician before undergoing the surgical procedure. The quoted fee also does NOT include any medical or surgical services for unexpected or unforeseen circumstances.

A 10% deposit will be required in order to secure a date for surgery. This portion of your fee is non-refundable but can be applied toward any rescheduling of your procedure within a 1 year period. Your deposit is refundable if Dr. Hidaji cancels your surgery for any reason. Dr. Hidaji reserves the right to cancel your surgery at any time for any reason up to and including the day of surgery.

The remaining balance will be due and must be paid in full *7* days prior to the scheduled date of your procedure. We will accept a personal check (if written 10 days prior to surgery), cashier's check, credit card or cash. If fees are not rendered at that time a hold will be placed on the surgery. If you cancel your surgery less than *7* days from your scheduled surgery date, the surgery fees are non-refundable and can be applied toward any rescheduling of your procedure within a 1 year period.

Plastic surgery is an art and occasionally revisions will be necessary. These will always be with in one year of the operating date. Most of the time, no surgeon fees will be charged, however a supply/set up cost of 10% of your original surgical fee will be charged. Dr. Hidaji reserves the right to determine what is a revision and what is a separate procedure that is being requested.

Any surgery that involves removal of skin lesions or abnormal tissue, such as moles or tumors, must be sent to the pathologist for identification. Lab fees are separate and are billed by the pathologist / laboratory providing these services.

PAYMENT
We accept VISA, MasterCard, Discover, money order, personal checks and cash. All returned checks will be subject to a service charge. Interest-free financing of up to 6 months is available to qualified individuals. Please ask our surgical coordinator for more information if you would like to finance your procedure.

INSURANCE
The expenses connected with cosmetic surgery are not covered by medical insurance. Occasionally cosmetic surgery is done in conjunction with a procedure designed to improve function or is reconstructive in nature. In these cases, your health insurance *may* cover part or all of the incurred expenses.

Although we are happy to assist you with your application for any reasonable insurance coverage, we cannot ethically, and will not, fill out any forms in such a way as to disguise the true purpose of any cosmetic procedures you wish to have done. Furthermore, even in cases that are clearly functional or reconstructive in my opinion, we cannot guarantee that your particular insurance company will agree with my findings and cover your procedure.

If your insurance company declines any of the fees associated with our services to you, even those billed as medically necessary but which were declined by your insurer as being cosmetic, medically unnecessary or an uncovered preexisting condition, you, the patient, are ultimately responsible for all charges incurred. You should consult the terms of your own benefit plan to determine if there are any exclusions or other benefit limitations applicable to the procedure of interest. In this manner, you can ensure all necessary requirements for coverage are known and met.

My signature below indicates that I have reviewed, understand, and agree with the policies stated above.

Patient: _____ Witness: _____ Date: _____