Rau
PLASTIC SURGERY

Financial Policy

Payment is due in full at the time of service or pre-operative appointment.

A deposit is required to schedule a procedure/surgery. The deposit is nonrefundable (in the event of cancellation), and transferrable to another date (in the event of reschedule). In the event that you decide your surgery needs to be rescheduled, a $200 rescheduling fee is required to reserve the new date as well as each time the date is transferred. Should the surgery be rescheduled by Rau Plastic Surgery or the facility the surgery is being performed at, a rescheduling fee will not occur. Additionally, should your scheduled procedure/surgery be cancelled a refund, excluding the nonrefundable deposit, may be issued 7-10 business days after the scheduled date of your surgery.

The remaining balance of your Rau Plastic Surgery Fee is due in full at the time of your scheduled pre-op. If you are unable to pay the balance, your surgery will be rescheduled, and a $200 rescheduling fee will be added to your balance. We accept all major credit/debit (Visa, Master Card, Discover, and American Express) cards, cash, and cashier's check. We also accept Care Credit payment plans.

I understand that payment is due in full at the time of service or pre-operative appointment. I understand that I am responsible for any outstanding balance. I, the undersigned, agree to pay all cost of collecting money past due including reasonable attorney's fees and to pay interest rate of 1 ½% per month until the account is paid in full. I hereby waive all rights of exemption under the constitution and laws of the State of Louisiana.

I hereby authorize the release of information including diagnosis and the records of any treatment of examination rendered to my child or me during the period of such care, to third party payers and/or other health practitioners. I hereby authorize photocopies of this form to be valid as the original.

I have read, understand, and agree to the Financial Policies described above. I agree that I will be responsible for the payment of all professional fees and will not dispute the charges. I fully understand that the procedure(s) being done are cosmetic and elective. I have chosen to pay for said procedure(s) out of pocket and will not try to seek reimbursement from Rau Plastic Surgery.

Patient Name: _____Date: _____

Patient Signature: _____ Date: _____

Physician Signature: _____Date: _____

Witness: _____Date: _____