

MediSpa Skin History

Are you or have you ever seen a dermatologist for your skin? Yes No

If yes, why? _____

Have you ever used Effudex, or had a Levulan treatment? Yes No

If yes, which? _____

Have you ever been diagnosed with skin cancer? Yes NoDo you have any skin allergies (contact dermatitis)? Yes No

If yes, what kind? _____

Do you appear reddened when you eat spicy food, drink alcohol, get angry, go in the sun, etc.? Yes NoDo you have permanent make-up? Yes No If yes, where? _____

Vascularity:

Broken capillaries or pronounced redness:

 Nose area Cheek area Chin area Forehead Entire face

Acne:

Do you have a history of significant acne or periodic breakouts? Yes NoIf yes, always, or related to your menstrual cycle? Yes No

Check all that apply:

 Pimples Whiteheads Blackheads Flakiness
 Acne scars Cystic acne Enlarged pores

Wrinkles:

Check all that apply:

 Forehead Between eyes Outer eyes (crows feet) Around your mouth CheeksHave you ever been treated with fillers? Yes NoHave you ever been treated with muscle relaxants (Botox, Dysport)? Yes NoHave you ever had a laser treatment? Yes No

If yes, what type? _____

Ability to Heal:

Does your skin appear fragile? Yes NoDo you form thick or raised scars? Yes NoDo you use wax or use depilatories on your face? Yes No

Hormones (women only):

During pregnancy, did areas of your face become hyperpigmented? Yes No N/A

Sun History and Lifestyle:

Do you work inside? Yes NoAre your hobbies mostly outside? Yes NoIn the past (including childhood), did you live in the sunbelt? Yes NoHave you ever experienced a significant sun burn? Yes No

If yes, approximately how many times and what areas? _____

Have you, or are you using tanning beds? Yes No

Skin Care History:

Are you currently having skin treatments? Yes No

If yes, what type of treatments? _____

Fox Valley Plastic Surgery, S.C.

www.fvpsurgery.com

Name: _____

2400 Witzel Avenue, Suite A
Oshkosh, WI 54904
920-233-1540
920-651-6951 Fax

2500 E Capitol Drive, Suite 1500
Appleton, WI 54911
920-358-1810
920-358-1819 Fax

DOB: _____

Please check if you are presently using or have used in the past any of the following.

- | | | |
|--|---|--|
| <input type="checkbox"/> Benzoyl Peroxide (BP) | <input type="checkbox"/> Glycolic Acid (AHA) | <input type="checkbox"/> Lactic Acid (AHA) |
| <input type="checkbox"/> Resorcinol | <input type="checkbox"/> Salicylic Acid (BHA) | |

Do you have or have you had any of the following in the last 14 days?

- | | | |
|--|---|--|
| <input type="checkbox"/> Facial Cosmetic Surgery | <input type="checkbox"/> Botox Injections | <input type="checkbox"/> Collagen Injections |
| <input type="checkbox"/> Fillers | <input type="checkbox"/> Light Treatments | <input type="checkbox"/> Laser Resurfacing |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Other _____ | |

Home Care:

What skin care products are you currently using?

- | | |
|-------------------|--------------------------|
| Cleanser _____ | Vitamin C _____ |
| Toner _____ | Exfoliants/Scrubs _____ |
| Moisturizer _____ | Specialty Products _____ |
| SPF _____ | Mask _____ |

Prescription Products:

- | | |
|--|---|
| <input type="checkbox"/> Tretinoin (Retin A, Retin-A Micro, Renova, Avita) | <input type="checkbox"/> Adepalene (Differin) |
| <input type="checkbox"/> Azelaic Acid (Azelex, Finacea) | <input type="checkbox"/> Tazarotene (Tazorac) |
| <input type="checkbox"/> Isotretinoin (Accutane) | <input type="checkbox"/> Triluma |
| <input type="checkbox"/> Metrogel | <input type="checkbox"/> Other topical antibiotics: _____ |

What skin conditions do you want to improve:

- | | | |
|--|--|--|
| <input type="checkbox"/> Acne and/or breakouts | <input type="checkbox"/> Facial Scarring | <input type="checkbox"/> Hyperpigmentation (freckles, age spots) |
| <input type="checkbox"/> Hypopigmentation | <input type="checkbox"/> Enlarged Pores | <input type="checkbox"/> Fine lines and wrinkles |
| <input type="checkbox"/> Other _____ | | |

List any other necessary information your Skin Care Specialists should know before beginning your treatment.

Signature: _____ Date: _____

Skin Typing Matrix

Please answer the following questions by checking the box next to the appropriate number which best describes you. Your clinician will total your score during the consultation.

| | | |
|---|---|---|
| My ethnic origin is closest to: | <input type="checkbox"/> Very fair (Celtic and Scandinavian) <input type="checkbox"/> Fair-skinned Caucasian with light hair and light eyes <input type="checkbox"/> Pale-skinned Caucasian with dark hair and dark eyes <input type="checkbox"/> Olive-skinned (Mediterranean, some Asian, some Hispanic) <input type="checkbox"/> Dark-skinned (Middle Eastern, Hispanic, Asians, some African) <input type="checkbox"/> Very dark-skinned (African) | |
| My eye color is: | 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | Light blue Blue / Green Green / Gray / Golden Hazel / Light brown Brown |
| My natural hair color at age 18 was: | 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | Red Blonde Light brown Dark brown Black |
| The color of my skin that is not normally exposed to sun is: | 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> | Pink to reddish Very Pale Pale with a beige tan Light brown Medium to dark brown Dark brown – black |
| If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will: | 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> | Burn, blister and peel Burn, then when burn resolves there is little or no color change Burn, but then turns to tan in a few days Get pink, but then turns to tan quickly Just tan Just gets darker My skin color is so dark I can't tell |
| When was the last time that the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream? | 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> | Longer than one month ago Within the past month Within the past two weeks Within the past week |
| Total Score: | | |
| If your score is: 0-3 4-7 8-11 12-15 16-19 20-24 | Your skin type is: 1 2 3 4 5 6 | If you sustain an injury to your skin, such as a cut, burn, or bruise, how long does it take to fully resolve without any hyperpigmentation? What happens if you get an insect bite? |

Signature: _____

Date: _____

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**RENAISSANCE MEDISPA and LASER INSTITUTE OF WISCONSIN™
CANCELLATION POLICY**

The Renaissance Medispa and the Laser Institute of Wisconsin™ reserves a time especially for you to be pampered and taken care of in a special way. We would appreciate a timely cancellation call if you are not able to keep your scheduled appointment with our qualified staff.

If you must cancel or change your spa appointment, please notify us at least 24 hours prior to your appointment time in order to avoid being charged a \$30 service fee. No shows will be charged 50% of the treatment value. Please note that if you arrive late for your treatment, it will end as scheduled so as not to delay the next scheduled client.

Thank you for understanding our Cancellation Policy. If you should have questions or problems, please let us know and we will be happy to assist you in every way possible.

I have read, understand, and agree to the above Cancellation Policy.

| | |
|--|--|
| | |
|--|--|

Patient's or Responsible Party's Signature

Date

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Demographics ~ <Appointment.Date>

First Name: _____ MI: _____ Last Name: _____ Former Name: _____

Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Cell Carrier: _____ Work Phone: _____

DOB & Age: _____ Race: _____ Ethnicity: Hispanic Non-Hispanic

Sex: _____ SSN: _____ Email Address: _____

Who is your primary care physician? _____
First Name Last Name

Preferred Pharmacy (name & location): _____

How did you hear about our practice?
 Patient: _____ Dr. Referral: _____
 Friend: _____ First Name Last Name
 Other: _____

Emergency Contact

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

HIPAA Notice of Privacy Practices

I have been given the opportunity to read, review, obtain a hard copy and ask questions about Fox Valley Plastic Surgery's **HIPAA Notice of Privacy Practices**, and how Fox Valley Plastic Surgery uses and discloses my information and my rights concerning my information. I consent and acknowledge my agreement to the terms set forth in the HIPAA information form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature: _____ Date: _____

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Consent to Communicate including Transmission of Protected Health Information by Non Secure Means (Email & Text Message)

In order to secure your Protected Health Information (PHI), it is always best to personally go to the office and talk to a representative of Fox Valley Plastic Surgery (FVPS). If this is not possible, the next best methods are to communicate by phone, fax, or U.S. mail. All these methods are secure means of transmitting PHI.

In spite of these secure options, it sometimes may become useful for during the course of treatment for the patient to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with FVPS, there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

FVPS has found that some patients prefer to message or email the office with photos or questions. These are not secure avenues of communication. If you wish the office to respond in kind to your inquiries, you must expressly give FVPS permission to communicate with you with these insecure methods instead of phoning, faxing, or writing you. Please mark the ways that you consent to us communicating with you.

| Communication Method | OK to Leave Voicemail? | OK to Leave Message with Another Person? | Preferred Method(s) | Best Time to Call |
|---|--|--|--------------------------|-------------------|
| <input type="checkbox"/> Call Work Phone | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | <input type="checkbox"/> | |
| <input type="checkbox"/> Call Cell Phone | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | <input type="checkbox"/> | |
| <input type="checkbox"/> Call Home Phone | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | <input type="checkbox"/> | |
| <input type="checkbox"/> Send Email | <input type="checkbox"/> Okay for appt reminder? <input type="checkbox"/> Okay for medical/schedule information? <input type="checkbox"/> Okay for special offers including patient surveys and newsletter? No spam. We do not sell our lists. | | | |
| <input type="checkbox"/> Send US Mail to | Mail to <input type="checkbox"/> present address, <input type="checkbox"/> permanent address, <input type="checkbox"/> employer address, <input type="checkbox"/> emergency contact, <input type="checkbox"/> responsible party | | | |
| <input type="checkbox"/> Send Text Message Cell Phone Carrier: | <input type="checkbox"/> Okay for appt reminder? <input type="checkbox"/> Okay for medical/schedule information? <input type="checkbox"/> Okay for special offers? | | | |

| FAMILY MEMBERS | | | | |
|----------------|---------------|--------------|-----------------|------------------------|
| Name | Date of Birth | Relationship | Release Results | Expiration or Comments |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my PHI by unsecured means. I understand that message and data rates may apply. I understand that I am not required to opt into emails or texting, or sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Patient Signature: _____

Date: _____

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Health History

Section I: Surgery and Anesthesia History

1. List and date your surgical history.

2. Do you have a blood relative who had anesthesia complications of any kind? No Yes, please describe:

Section II: Specific Medical History

HEIGHT & WEIGHT: _____

Do you have a history of the following?

| | No | Yes | Description |
|---|--------------------------|--------------------------|-------------|
| 1. Anemia | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Asthma | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Bleeding tendency | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Blood clots | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 7. Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 8. CHF | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 9. COPD | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 10. Depression | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 11. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 12. High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 13. Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 14. Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 15. Herpes/Cold Sores | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 16. Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 17. Melanoma | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 18. Migraine headaches | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 19. Multiple Endocrine Neoplasia (MEN) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 20. Pancreatitis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 21. Periodontal disease – currently being treated | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 22. Stroke | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 23. Thyroid Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 24. Thyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 25. Problem Scarring | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 26. Have you been advised to or had psychiatric care? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 27. Vein problems, such as venous reflux disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 28. Others Not Listed | | | _____ |

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Section V: Medications

List any medications, and oral or topical vitamins or herbal supplements you are taking.

| Name of Medication | Strength (mg) | How many times a day? |
|--------------------|---------------|-----------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Do you have a Pain Contract with another physician? No Yes

Section VI: Allergies and Sensitivities

List all allergies and sensitivities:

| Allergy: | Severity: | Reaction: (list #'s from bottom) |
|----------|---|----------------------------------|
| | <input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown | |
| | <input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown | |
| | <input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown | |
| | <input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown | |
| | <input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown | |
| | <input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown | |
| | <input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown | |
| | <input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown | |
| | <input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown | |

Reaction List: 1) Arthralgia, 2) Chills, 3) Cough, 4) Fever, 5) Headache, 6) Hives, 7) Malaise/Fatigue, 8) Myalgia, 9) Nasal Congestion, 10) Other, 11) Pain/Soreness at injection site, 12) Rash, 13) Rhinorrhea, 14) Shortness of breath/Difficulty breathing, 15) Sore Throat, 16) Swelling, 17) Unknown

Are you allergic to medical adhesives such as tape, steri-strips, bandaids? No Yes, please list:

Are you allergic to any medications or local anesthesia? No Yes, please list:

Section VII: Women Only

Date of last mammogram: _____ Number of pregnancies: _____

Do you do regular breast self-exams? Yes No

Do you breast feed? Yes No

Breast lump or discharge? Yes No

Are you pregnant or trying to get pregnant? Yes No

Are you on birth control pills or hormone replacement therapy? Yes No

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____

Date: _____

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Financial Policy

Appointment scheduling requires careful planning and coordination between our office, surgery centers and contracted staff. Special medical instrumentation and supplies may be ordered and are sterilized for each individual procedure. Please consider the importance of this policy before scheduling a procedure.

SURGERY SCHEDULING

A \$1,000 down payment is required to secure a scheduled surgery time. **Full payment is due 21 days prior to a scheduled surgery date.** This includes complete payment of deductibles, co-insurance and copays for insurance cases. Immediately upon scheduling, patients have a **24-hour grace period** to make changes including cancelling the surgery without incurring a rescheduling/cancellation charge.

SURGERY RESCHEDULING / CANCELLATION FEES

Patients who wish to change the surgery date or cancel surgeries, will incur a fee. Patients, who **fail a cotinine test**, are considered patient cancellations. Adequate notice of cotinine testing is always given, so there is no reason for a failed test. A rescheduling/cancellation fee will be assessed on failed cotinine tests. Fees are first withheld from any down payments already paid before invoicing the patient. The fee schedule is as follows:

| Days Prior to Surgery | Rescheduling Fee | Cancellation Fee |
|-----------------------|------------------|------------------|
| Over 21 days | \$200.00 | \$300.00 |
| 15-21 days | \$400.00 | \$500.00 |
| 8-14 days | \$600.00 | \$700.00 |
| 1-7 days | \$800.00 | \$900.00 |
| 24 hours or less | \$1000.00 | \$1000.00 |

NON-SURGERY RESCHEDULING / CANCELLATION FEES

Generally, full payment is due on the day of service for non-surgical procedures such as those in the Renaissance Medispa and the Laser Institute of Wisconsin™. Some procedures have a non-refundable \$250 fee payable at the time of booking. The booking fee will be applied to the cost of the actual procedure, or used to cover the cost of consumables and room setup, if the patient cancels the appointment without adequate notice. You will be notified if your service requires a booking fee.

If you must cancel or change your non-surgical appointment, please notify us at least **24 hours** prior to your appointment time so that we can try to fill your slot with another patient. Without this advance notice, you will either forfeit your \$250 booking fee, if applicable, or be charged a **\$50 service fee**. This also applies to **no-shows**.

It is your responsibility to call us if you wish to reschedule. Your appointments, such as in veins, may have a sequential and cumulative sequence that must be followed. If one appointment is missed, the rest are timed incorrectly and must be rescheduled. If we cannot contact you, or you do not contact us, then all your remaining appointments will be cancelled.

If you arrive late for your treatment, you may be asked to reschedule, so as not to delay the next scheduled client.

ALLOWABLE FORMS OF PAYMENT

Our office accepts payment by cash, check, money order and credit cards from Visa, Mastercard, Discover and American Express. We also offer patient financing through Care Credit and Alphaeon Credit. Not all patients will qualify for financing, and not all procedures are eligible to be financed.

INSURANCE: CO-PAYS, DEDUCTIBLES, CO-INSURANCE, DENIALS

Our office is happy to file claims with your insurance company as a courtesy. However, your insurance policy is a contract between you and your insurance company. Verification of benefits is not a guarantee of payment. You are responsible for understanding your coverage. You are financially responsible for 1) co-pays, deductibles, and co-insurance, 2) services not covered by your insurance, 3) services your insurance denies for any reason, and 4) charges not paid by your insurance plan. If your insurance does not pay for a service, you agree to be responsible for the remaining balance. Some services require prior authorizations or referrals. While we may assist in obtaining them,

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payment is not guaranteed by authorization approval. If your insurance denies payment, you are responsible for the balance.

The patient or his/her legal representative is ultimately responsible for all charges incurred. Our office accepts assignment of benefits for many insurance companies. However, we are not preferred providers with all of them. It is your responsibility to **contact your insurance as to whether we are in your plan**, obtain your individual benefits and to be prepared to pay for any out-of-pocket expenses such as co-pays, deductibles and co-insurance before any surgery or office procedure is done. **Co-pays, estimated patient balances, and past due balances are due at time of check-in.**

Medicare does not have a pre-authorization process for most procedures. If it is determined that your surgery was not medically necessary, you will then be billed for the surgery. It is ultimately **your responsibility to pay for all services** provided by Fox Valley Plastic Surgery.

BILLING

Statements are mailed monthly and expected to be paid in full within 60 days after your insurance has settled your claim. If you have financial difficulties, please contact our Financial Supervisor as soon as you are aware of the situation. The worst thing that you can do is to ignore the bill. Doing so will make you ineligible for any further service. Payment plans may be available upon request. If payment is not received within 90 days, your account may be sent to a collection agency.

DISPUTES

Performed services that are paid with a credit card, debit card or with financing, are not eligible for post-care payment challenges. Fox Valley Plastic Surgery encourages a complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this credit, debit card or financing challenge agreement is irrevocable.

I have read the above Financial Policy. I understand and agree to this.

Patient
Signature: _____ Date: _____