_____
Patient's Name

_____
Date of Birth

ESTETICA
Practice Administrator
9450 E. Ironwood Square Dr.
Scottsdale, AZ 85258
Phone: (480) 551-0581
Fax: (480) 551-0585

FINANCIAL POLICIES

In order to enhance communication and promote understanding regarding Estetica's Financial Policies, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please ask to speak with the Office Administrator. Thank you!

- **No Shows/Missed Appointments -** We request notice to cancel or reschedule an appointment at least 48 hours in advance. With less than a 24 hour notice given, a charge of $50 may be assessed to the patient's account and card on file will be used to take care of this balance.
- **Insurance -** We are happy to bill both primary and secondary insurance as a **courtesy** for our patients. It must be understood that each patient is financially liable for all services performed that are not covered by the insurance company or if the coverage is not in effect at the time these services are rendered. I understand that I am responsible for confirming my coverage limitations and policies set forth by my insurance company and that any outstanding balances after estimated costs are paid to Dr. Corwin D. Martin are my responsibility.
- **Patient Payment -** I understand that all payments are due at the time services are provided unless *previous* arrangements have been made with the treatment coordinator. I understand there is a $35.00 fee for all returned checks.
- **Refunds For Unfinished Treatment -** I understand that deposits made towards a surgery are **NON-REFUNDABLE.** I further understand that if payment is made towards surgery and it is canceled by me, a full refund will not be given. Individual circumstances may be discussed with the Office Administrator.
- **Collections -** I agree, if my account is turned over to a collection agency for non-payment, to pay the fees of the collection agency equal to the maximum of 25% of the outstanding balance at the time the account is placed with the collection agency. Interest of 10% per year will be accrued on the principal balance placed with the agency. Should legal action be necessary to collect the account, I agree to pay attorney's fees and court costs incurred for collection. I understand that any outstanding bad debts, for which I am not making consistent monthly payments, will be reported to the CREDIT BUREAU.
- **Card On File -** Name on Card _____
  Card # _____ Exp_____ CVV_____ Zip_____

I have read and understand this agreement:

_____
Patient's (or Legal Guardian's) Signature Date

_____
Print Patient's (or Legal Guardian's) Name/Relationship Date

Patient's Initials _____

Estetica Cosmetic and Reconstructive Surgery of Scottsdale
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