

PLASTIC **EYE** SURGERY ASSOCIATES  
**PAYMENT POLICY**

Thank you for choosing our practice to help with your surgical needs. The following policy has been developed to be fair to everyone including you, other patients waiting for surgery, anesthesiology staff who take time off from their regular full-time hospital-appointed positions, our office staff, and your surgeon.

**DEPOSIT**

For cosmetic procedures, a **\$300 non-refundable deposit** is required at the time of scheduling.

---

For insurance-covered procedures, a **\$50 non-refundable deposit** is required at the time of scheduling. If cosmetic procedures are being performed at the same time, a total deposit of only \$300 is required.

---

**RESCHEDULING**

We understand events may arise which may make it impossible for you to keep your surgery appointment. Please communicate all cancellations directly to our Surgery Scheduler, **Ana Maria**, or our office Manager, **Ms. Broussard**. Please give us as much notice as you can. Depending upon whether we have enough notice to fill your spot and/or whether insurance-covered or hospital-based procedure leg-work needs to be duplicated, a repeat deposit may be required to reschedule your procedure.

---

**PAYMENT DUE**

Full payment for surgery is required at least five (5) working days in advance of all elective surgery. For insurance-covered procedures, we will provide you with our very best *estimate* based upon anticipated surgical procedures and the most current fee schedules provided by your insurance company. If you are using an anesthesiologist in our office, then full payment for this service is required five (5) working days before your surgery as well.

If you decide you would like to use a different credit card, than the one used at time surgery was scheduled, you will need to contact us 10 days prior to surgery or risk an additional 9% processing fee.

---

**CREDIT CARD PAYMENTS**

We are happy to accept credit card payment at no additional charge to you. However, if you must cancel or reschedule your surgery *and you require a refund processed on your credit card*, then we must pass along to you a nine percent (9 %) **processing fee** to cover state franchise taxes and the intermediary charges.

---

Patient's Name

---

Date of Surgery

---

Patient's Signature

---

Date Signed