

Financial Policy

This is an agreement between Foley Plastic Surgery Center, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you", "your" and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name to which charges were made and payments credited. The words "we", "us", and "our" refer to Foley Plastic Surgery Center.

By executing this agreement, you are agreeing to pay for all services that are received.

Consultation fees: Consultation fees are due upon scheduling and are nonrefundable.

Surgical Fees: I understand that the scheduling deposit is non-refundable. The surgical fee **does not** include laboratory fees before or after surgery, pathology bills, hospital fees, prescriptions, etc.; these are paid directly to the provider. I understand that a \$50 rescheduling fee will be charged to me each time I reschedule my surgery date. I also understand that if I should cancel or reschedule my surgery within 2 weeks of my scheduled date, I am subject to a 20% charge.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. In case of suit, you agree the venue shall be in Thurston County, Washington.

Returned checks: There is a \$45 fee for any checks returned by the bank.

CareCredit: Patients are welcome to use their CareCredit card in our office and you authorize us to accept payments, at your request, via phone, mail, or in office. By signing you acknowledge that you are financially responsible for all CareCredit charges.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our offices may become a matter of public record.

Missed appointment fee: Patients who do not show up for an appointment or cancel with less than 24 hours notice may be charged a \$20 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be asked to transfer their records to another doctor.

Transferring of records: You will need to request in writing, complete a medical release form and pay a reasonable copying fee of \$21 If you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including payment history. If you are requesting your records to be transferred from another doctor to us, you authorize us to receive all relevant information, including your payment history.

Once you have signed this agreement you agree to all of the terms and conditions contained herein and the agreement will be in force and effect.

Patients Name: _____

Responsible Party: _____
(if not the patient)

Signature: _____

Witness Signature: _____

FOLEY PLASTIC SURGERY CENTER

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