Payment Contract

Congratulations _____. We are thrilled that you have selected Dr. Niki A. Christopoulos, M.D. and Chicago Cosmetic Surgery and Dermatology for your cosmetic surgery procedure. As you are aware, most health insurance plans do not cover cosmetic surgery procedures. Thus, this document will serve as your Payment Contract to personally pay charges and fees for services and supplies set forth below associated with your scheduled cosmetic surgery. As discussed in your consultation, you are electing to have the following surgical procedure:

A total fee amount of..... will be collected prior to the scheduled date of surgery and will cover the services listed below:

1) Professional fees for Niki A. Christopoulos, M.D.
2) Facility charges for CCSD for the following:
    a) Pregnancy test as medically indicated
    b) Operating Room: estimated operating room time as stated above, supplies, equipment, medications, and staff / nursing time
    c) Anesthesia – anesthesia supplies, medication(s) and equipment
    d) Post-Surgical Recovery: recovery room time, equipment, supplies and nursing care, anesthesia care during recovery time.
3) Professional fees for Anesthesia services
4) Implant costs (if needed)
5) Professional fees for Radiologist, Cardiologist, and Pathologist (if necessary)
6) All pre-operative and post-operative visits
7)

An inpatient stay is not anticipated, however; in the event admission to the hospital for services not provided in the outpatient setting is required, you will incur additional expenses at the hospital's reasonable and customary rate. The fees, as listed above, do not include admission to the hospital. You will be responsible for any and all fees for hospital and professional services (inpatient and outpatient) not included in the fee amount stated above.

Furthermore, you may have an "Exclusion and Limitations" clause in your health insurance policy which may read: "Complications of non-covered services, including the diagnosis or treatment of any condition which arises as a complication of a non-covered service (i.e., services or supplies to treat a complication of cosmetic surgery) are not covered." Please carefully review your health insurance policy.

This procedure is being performed as a self-pay procedure and as such, neither Niki A. Christopoulos, M.D. nor Chicago Cosmetic Surgery and Dermatology will be submitting any claims seeking reimbursement from your insurance carrier at any time or for any reason. It is also understood that generally, most insurance carriers require prior authorization for surgical procedures. Should you personally attempt to submit a claim to your insurance carrier for reimbursement of the cosmetic procedure described above, your claim will not be paid by your insurance carrier, as no prior authorization will be conducted on your behalf.

By your signature below, you indicate that you have read and understand the terms of this legally binding Payment Contract and that all your questions have been answered to your satisfaction. You agree that you will be responsible for the payment of any and all additional fees for services not included in the fee amount above.

Patient Name (print) **Patient Signature** **Witness Name (print)** **Witness Signature**

Date **Date**