CHESAPEAKE AESTHETIC SURGERY

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I, _____, understand that my insurance company does not cover the physician's fee in connection with my surgical procedure for _____ _____and I agree to pay such amount which is estimated below. I understand that since this procedure is cosmetic/aesthetic, it has no contracted procedure code, it is not covered by my insurance and I am therefore considered a self pay patient. Consequently, Chesapeake Urology Associates will not submit a claim to my insurance carrier for reimbursement.

In signing this waiver, I understand that I am a fee for service patient and, as such, am responsible for payment of all of the fees associated with any services provided to me in connection with this procedure by Chesapeake Aesthetic Surgery.

In signing this waiver, I understand that I will incur a cancellation fee of $ 500 if I cancel the surgical procedure within two weeks of the surgical date. Additionally, if the procedure is not rescheduled within 2 weeks of _____, the $200 consult credit is not applicable.

Procedure: _____

Date Scheduled: _____

Facility Location: _____

Estimated fee for professional services/surgeon: $_____

Estimated fee for facility: $_____

Estimated fee for anesthesia: $_____

Patient Signature_____Date_____

Witness Signature_____Date_____

**If you have IVF benefits, we will provide you with a receipt, after payment is received, to submit to your insurance carrier.

Karen Elizabeth Boyle, M.D., Director
6535 North Charles Street / Physicians Pavilion North, Suite 625 / Towson, MD 21204 / 410-825-5454 Phone / 410-825-5811 Fax
www.ChesapeakeAestheticSurgery.com