Financial Policy Regarding Revision and Complications

Every plastic and reconstructive surgeon has a few patients who will require revision or have some complications requiring additional surgery. As you have been or will be told, one cannot guarantee a result. In cosmetic procedures there are certain problems that will happen statistically no matter how good the care or how careful the doctor and team. Examples of problems that may be encountered are bleeding or an unfavorable scar after a surgical procedure. In both of these cases, it may be necessary to return the patient to surgery, either on an emergency basis (as in the case with bleeding) or an elective basis (as in the case of scarring). It is our policy as a predetermined courtesy to our patients not to charge a surgeon's fee for complications or revisional surgery within 6 months from the original surgery date. We do, however, expect the patient to pay whatever other expenses arise as a result of treatment in hospital or outpatient settings. If the revisional surgery occurs in our office facility, the patient is responsible for the expense of the facility and anesthesia. Sometimes the patient will have insurance that will cover these revisions or complications. It depends upon the individual policy and how it is written. When a person does have insurance, the insurance company is billed for the surgeon's fee as well as the facility fees.

We hope that no complication arises and no revisional surgery is necessary in your case. However, no plastic surgeon can guarantee this to their patients. It is important for the patient undergoing an elective surgical procedure to understand this financial policy. If you have any questions regarding this policy, the office staff would be happy to discuss it with you.

Patient is a minor years of age, and we, the undersigned, are the parents or legal guardian of the patient and do hereby have legal authority to consent and do consent for the patient.

My signature below, indicates that I understand and agree to the above policy.

Signature _____ Date _____

Witness _____

Patient Initials: _____