

Women's Physician Surgery Center
Cosmetic Split Agreement

This agreement is to help the process of cosmetic split procedures and also ensure that the patient has a clear understanding of what their financial responsibility will be. Cosmetic split means that the patient will be having an elective cosmetic procedure (self pay) and a medical necessary procedure (insurance). Please contact a member of our business office for any questions the patient might have at 317-228-1100. This agreement must be signed and payment received prior to surgery.

Self Pay

Women's Physician Surgery Center collects the self pay fees for the patient's Anesthesiologist; however to contact their billing company for any questions or statements please call 317-567-2179 x 550.

In the event the actual surgery time or surgery procedure differs (i.e., if the procedure changes to include an additional procedure or exclude one), the patient will be responsible for any additional charges provided by the surgery center. The additional charges must be paid to the surgery center on the same day of the procedure. Failure to meet this requirement will be the patient's responsibility for 100% of the billed charges.

Payment can be made via 1) cash (exact amount), 2) cashier's check, or 3) credit card and must be received with the signed agreement prior to surgery.

\$ _____ WPSC and \$ _____ Anesthesiologist

The fees above are for the surgery center and anesthesiologist SELF PAY portion only. They include a self pay discount and are based solely on operating time.

The fees do NOT include the physician fees, labs or pathology, and radiology fees.

_____ Patient initials-Certifies that he/she has read and understands the above information

Insurance

The procedure that is medically necessary will be billed to the insurance company provided. The surgery center recommends calling 317-338-8035 to receive an estimate on what will be billed to the insurance company. The customer service representative will need the CPT code and the estimated time, which the physician's office should provide. Please be aware that the patient will be responsible for any deductibles or co-insurance. To better understand the patient's financial responsibility the patient may need to contact the insurance company personally and discuss how much the insurance company will be responsible for.

I, _____, have read the requirements outlined above and I agree to all the terms stated above.

Patient Signature

Date

Witness

Date