Patient Rights, Privacy & Financial Acknowledgement

Thank you for choosing Wayzata Cosmetic Surgery & Spa, and welcome to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as comfortable as possible.

1. **Payment Options.** An important part of our mission is to make the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. Acceptable forms of payment include: Cash, Check, Credit Card, or Care Credit[1]. We will also accept HSA card payment if your care is considered acceptable by your insurance provider.

2. **Insurance and non-covered services.** We do not participate in insurance plans. Payment in full is expected at each visit. If you are insured, you may choose to submit receipt of your payment to your insurance provider for consideration of reimbursement. We are not party to the contract between you and your insurance company and knowing your insurance coverage is your responsibility. Please be aware that some and perhaps all of the services you receive may be non-covered, considered investigational by some health plans, or not considered reasonably necessary by Medicare or other insurers. Please contact your insurance company with any questions regarding your potential coverage or potential reimbursement.

3. **Cancellation Policy**. Time has been specifically reserved for your appointment. We kindly request at least a 24 hour notice to cancel or reschedule an appointment. If you fail to cancel your appointment at least 24 hours ahead or fail to show up for your scheduled appointment more than 1 time in a calendar year, you will be required to provide a credit card to schedule all future appointments and a $100.00 fee will be charged for any future cancellations or no shows that do not abide by this policy. If you need to change or reschedule your appointment, please call (952) 473-6642.

4. **Series.** Treatments purchased as a part of a series package must be used within the allotted time per the specific treatment plan and cannot be extended past 1 calendar year of the purchase.

5. **Returned checks.** Please be advised there is a $50 fee for any bounced or returned checks.

6. **Notice of Privacy Practices for Protected Health Information.** I acknowledge that I have reviewed the Notice of Privacy Practices that describes how my health information is used and shared and that if I wish to receive a copy of this notice, I may request it from the clinic. I understand the organization has the right to change this notice at any time. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

I acknowledge the above policies and practices and agree to abide by its guidelines.

_____ _____

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient:

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[1]Subject to credit approval