JASON B. DIAMOND, M.D., F.A.C.S.
THE DIAMOND
FACE INSTITUTE

9400 BRIGHTON WAY • PENTHOUSE SUITE • BEVERLY HILLS, CA 90210

PATIENT'S FINANCIAL POLICY

This policy must be read and signed prior to seeing Dr. Jason Diamond. This policy is subject to change at any time. Should you have any questions or concerns, please feel free to discuss them with the staff.

PAYMENT IS DUE AT TIME OF SERVICE
We accept Cash, Visa, MasterCard, American Express, and Care Credit. We only accept checks for deposits and payments towards surgery. The consultation fee is $1000.00 and will be applied toward surgery upon scheduling. In order to schedule and reserve your surgery, a $2,500.00 deposit is required and also applied to your surgery fees. The balance and full amount is due three *weeks* prior to your scheduled surgery date._____(initial)

Payments made by credit card or wire transfer are not charged additional bank fees; however, in the event of a credit/refund transaction, 5% of each and any transaction originally paid by credit card or wire transfer will be assessed and withheld from the total refund for bank processing fees. For example, a $100 refund originally paid by a credit card or wire transfer will be paid $95 in total.

CANCELLATION POLICY
Should you need to cancel your surgery for any reason without rescheduling *less than two weeks prior to your surgery date, 50% of your total surgical fee will be non-refundable*. If cancellation is made more than two weeks prior to your surgery date, the full amount will be refunded less the $2,500.00 deposit. The original $2,500.00 deposit will be applied toward a new surgery date if rescheduled within four months of the original date, otherwise a new deposit will be required. *If cancellation is made 48 hours or less prior to your surgery date, the total surgery fee paid will be non-refundable*.

In the uncommon circumstance that you need a return to the operating room following your surgery for any reason, you will be responsible for additional operating room and anesthesia fees.

I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

SIGNATURE _____ **DATE** _____/_____/_____
Patient or Responsible Party

PRINT NAME _____