

SURGERY PRE-PAYMENT AGREEMENT

DATE: _____

PATIENT NAME: _____

MAILING ADDRESS: _____



PATIENT NAME: _____ Account #: _____ Dr. _____

DATE OF SERVICE: _____

FROM: _____ / _____ / _____ TO: _____ / _____ / _____

CPT CODES/SERVICES: _____
 OR CONFIRMATION: _____

SERVICE/PROCEDURE DESCRIPTION	CHARGE AMOUNT	QUANTIT Y	PATIENT RESPONSIBILITY
COSMETIC SURGERY - OPERATING ROOM FEE			
FIRST HOUR	\$900		
EACH ADDITIONAL 30 MINUTE INCREMENT OR PORTION THEREOF	\$260		
COMBINATION COSMETIC/INSURANCE SURGERY			
COSMETIC PORTION - 30 MINUTE INCREMENT OR PORTION THEREOF	\$260		
IMPLANTS (IF PROVIDED BY THE CHRIST HOSPITAL)	VARIES		
ROOM CHARGE & EXTENDED RECOVERY	\$525/DAY (SEMI-PRIVATE)		
TOTAL			

Initial below

_____ The above referenced patient has agreed to enter into this Agreement with The Christ Hospital for the above self-referred services and has declined to have the Hospital submit these services to their health plan. The signing of this Agreement commits the above referenced patient to payment of all Hospital charges for the services provided under this Agreement. Waiver by The Christ Hospital hereof to enforce any provisions of this Agreement shall not operate to bar The Christ Hospital's rights to enforce any provisions of this agreement at any later time or for any later default.

_____ In the event legal action is brought by The Christ Hospital to recover payment under this Agreement or to enforce any term of this Agreement, The Christ Hospital shall be entitled to such legal fees, costs, and expenses of such action.

Additional Terms

1.	A history and physical is required before surgery. Additional charges may be incurred from the physician performing this service. Any additional charges are the responsibility of the patient.
2.	Additional charges may be incurred for anesthesia, pathology, radiology and cardiology services directly from the physician(s) or midlevel(s) performing these services. Payment arrangement(s) are the responsibility of the patient.
3.	Due to general lack of insurance coverage for cosmetic procedures, Hospital will not bill insurance payers.
4.	In the unlikely event that additional surgery is needed to correct a minor complication (i.e. hematoma) within 30 days from the time of surgery, patient will be charged according to the above rate schedule and agrees to pay the same Cosmetic Surgery Pre Payment rate as for the original operation based upon the duration of the operation. Private insurance will not be billed for this case.
5.	Payment in full for The Christ Hospital Health services must be received seven (7) business days prior to the procedure being performed or the procedure will be cancelled.

Continued on Back

6.	Extended Recovery: In the event the patient is not able to be discharged from hospital within four (4) hours post-surgery, a room charge will be assessed at the current rate. The Christ Hospital cannot reserve or otherwise guarantee private room accommodations.
7.	In the event that you need to cancel your procedure; 48 hour notice must be given and 72 hours if holiday related. A late notice cancellation fee of Two hundred fifty dollars (\$250.00) will be assessed for appointments that are cancelled within 48 hours of the schedule date and 72 hours if holiday related.

By my signature on this Agreement, I certify, attest, and represent that I have received, read, understood, and will abide by the terms of the Agreement.

PATIENT SIGNATURE	DATE	FINANCIAL COUNSELOR SIGNATURE
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METHOD OF PAYMENT

CARD TYPE: _____	CARD HOLDER NAME: _____
CARD # _____	EXP. DATE: _____ CVV CODE: _____
BANK: _____	ROUTING NUMBER: _____ ACCOUNT NUMBER: _____

To Pay By Credit Card, Call: (513) 585-2302

Payment should be mailed to:

The Christ Hospital
 ATTN: Financial Counselor, C Level Registration
 2139 Auburn Ave.
 Cincinnati, Ohio 45219
 (513) 585-2302

I have reasonably estimated the expected surgical time required for this surgical visit and have advised patient. I understand that in the event that surgical time exceeds the above listed time by ten (10) minutes, then each additional 15-minute increment will be the responsibility of the surgeon. The surgical time is based on time from when the patient is taken into surgical suite until the time patient is transferred to the Recovery Room (PACU).

Physician Signature	Date	Time
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