COSMETIC SURGERY CENTER
at the GW Medical Faculty Associates

2300 M Street NW, 6th Floor
Washington, DC 20037
Phone: 202.741.3241
Fax : 202.741.3183

Michael Olding, MD, FACS
Chief, Plastic & Reconstructive Surgery
Director, Cosmetic Surgery Center

FINANCIAL RESPONSIBILITIES CONSENT

The cost of surgery involves several charges for the services provided. The total includes fees charged by your surgeon, the cost of surgical supplies, anesthesia, laboratory tests, and possible outpatient hospital charges, depending on where the surgery is performed. Depending on whether the cost of surgery is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered. The fees charged for this procedure do not include any potential future costs for additional procedures that you elect to have or require in order to revise, optimize, or complete your outcome. Additional costs may occur should complications develop from the surgery. Secondary surgery or hospital day-surgery charges involved with revision surgery will also be your responsibility. **In signing the consent for this surgery/procedure, you acknowledge that you have been informed about its risks and consequences and accept responsibility for the clinical decisions that were made along with the financial costs of all future treatments.**

Please initial each paragraph after reading carefully.

______ I understand that with cosmetic surgery, I am responsible for the surgical fees quoted to me, as well as additional fees for anesthesia, facility (OR), and possible laboratory, X-ray, and pathology fees.

______ Surgicenters, Outpatient Centers, and Hospitals often have rules that certain tissue/implants removed during surgery must be sent for evaluation which may result in additional fees. Please check with your surgeon to receive an estimate of any additional costs that you may be charged.

______ I understand that there will be a non-refundable fee for booking and scheduling my surgery of **$500.00**, which is a part of the overall surgical fee. Should I cancel my surgery, this fee is forfeited. While this may appear to be charge for services which were provided, this fee is necessary to reserve time in the OR and in the practice, which are done when I schedule.

______ I understand and unconditionally and irrevocably accept this.

______ **COSMETIC SURGERY IS ELECTIVE AND NOT COVERED BY YOUR HEALTH INSURANCE.**

____
Patient or Person Authorized to Sign for Patient

______________________ ______________________
Date Witness