

LRS- Anterior Legs and Thighs

Quote Creation Date: 08/07/2023

Quote ID: Q0000FR

Name: Affleck, Stephanie
DOB: 11/02/1970 MRN: MM0000000737
Responsible Party: Self Pay

Provider: Schwartz, Jaime
Created By: Escobar, Evyn

Procedures	Fee
Lipedema Reduction Surgery - Bilateral Anterior Legs	\$10,000.00
Operating Room Fees	\$3,200.00
Anesthesia Fees	\$1,600.00
Cosmetassure	\$500.00
Garment - Body	\$500.00
Professional Fees:	\$15,800.00
Total:	\$15,800.00

Notes

Financial Quote

Financial Quote: This quote is valid for 60 days. After 60 days, please contact the office for an updated quote. Expired quote rates will not be honored. Included in your financial quote are all pre and post-operative visits for the first year after surgery. Please note that you will be required to fill various prescriptions, obtain medical clearance, labs and other tests which are your financial responsibility and are not included in this quote. Any travel related expenses or aftercare are also your financial responsibility and are not included in this quote.

Insurance

(If applicable) Once the TLC Team has completed the insurance process for my case, I will be notified of my dues owed such as copays, coinsurance or deductible. Please note that you will be required to fill various prescriptions, obtain medical clearance, labs and other tests which are your financial responsibility and are not included in this quote. Any travel related expenses or aftercare are also your financial responsibility and are not included in this quote. I have also been given the Insurance Agreement to review and sign in order to move forward with the insurance process. I understand that any reimbursement made to me will be less the 15% office administrative fees.

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Payment

A \$5,000.00 deposit is required to secure your procedure date. The deposit is non-refundable. Your balance is due in full 30 days prior to your scheduled procedure date. Payment can be made by credit card, wire transfer, cashier's check, personal check or cash. You can also use a financing company such as Care Credit, Alphaeon, or Lending USA.

Refunds

Refunds are subject to approval and are approved at the sole discretion of the business. Refunds will be completed in the same method the initial payment was made. If payment is made using a credit card, the refund must go back to the same card used for payment. Once requested, refunds can take up to 30 days processing time. If you request a refund due to cancellation (within the contracted time frame allotted), funds will be returned minus merchant processing fees.

Requirements

TLC Surgical Center requires Medical Clearance documentation to be submitted and received 14 days prior to your surgery date. This policy is to ensure your safety as the patient and our preparation as health care providers. If your completed Medical Clearance documentation is not received by 14 days prior to your surgery, your surgery may be canceled and you may be charged a \$5,000.00 rescheduling fee. If these requirements are not completed, the patient will forfeit the surgical date as well as any deposit or payments already made.

Revisions or Complications

Complications, hospital admission, or additional surgery(ies) may be necessary. This quote will not cover those costs. It is advisable to check with your insurance carrier prior to your surgery regarding their policies related to cosmetic surgery. Plastic surgery is an art, and occasionally revisions are necessary. Revision surgeries must be scheduled within one year of the initial surgery after all of the required post-op appointments have been attended. Although the surgeon's fee may be waived (at the sole discretion of the office) facility and anesthesia fees will apply and are the sole responsibility of the patient. Dr. Schwartz reserves the exclusive right to determine what is considered revision surgery and a new, stand-alone procedure.

Scheduling

Surgeries can be rescheduled more than 30 days from the original surgery date one time at no additional charge. If the surgery is rescheduled more than once, there will be an additional rescheduling fee of \$5,000.00. If rescheduling for medical reasons, the rescheduling fee will be waived one time if the patient presents a valid Doctor's note.

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Signature

Your signature below confirms that you have read and understand the above policies with our office. Your signature below confirms that you fully understand the fees and related policies outlined above. Your signature below also confirms that this is a quote for the procedure(s) listed above and is no guarantee, of any kind, as to the outcome.

Patient Signature: _____