Santa Barbara Plastic Surgery Center (SBPSC)
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Many surgeries are not covered by managed care plans and insurance companies including cosmetic surgery and services deemed "experimental" and/or "investigational." Each health plan may exclude or limit coverage for other services.

Certain procedures performed may be deemed as cosmetic or not medically necessary and are usually NOT covered by your insurance. Some of these services include but are not limited to: breast reduction, removal and/or replacement of ruptured breast implants, mastopexy, septorhinoplasty, blepharoplasty abdominoplasty , and/or panniculectomy.

Most procedures including full abdominoplasty, body lifts, replacement of ruptured breast implants and any cosmetic surgery are almost never covered by insurance and fees for these procedures and services will need to be collected prior to any of these procedures.

In the unlikely event that a procedure is paid for by your insurer directly to our office, you will be refunded the balance amount if the combined collected amount is greater then the billed amount. In many cases after insurance is billed the patient will lose their discount for procedures performed at SBPSC and may end up incurring additional costs.

The laws of California prohibit some exclusions, but only for health plans that are licensed by the state. You need to discuss with your insurer or plan whether treatment provided at SBPSC is covered and therefore paid for by the plan.

If you have any questions about the law you may also contact California's Department of Managed Health Care (DMHC) by calling (888) HMO-2219, www.dmhc.ca.gov/aboutthedmhc/gen/gen_contactus.aspx or the Department of Insurance (CDI) at (800) 927-HELP, www.insurance.ca.gov/0100-consumers/0400-talk-to-us/.

You are responsible for full payment for all services provided to you.

AGREEMENT TO PAY FOR NON-COVERED SERVICES:

I, _____(Patient Name), understand that the operation prescribed by my physician may not be covered by my insurer or health plan and therefore the service may not be paid for by my insurer or plan. I agree, in advance, to pay his usual and customary rate for providing operation and/or services to me. I understand that Santa Barbara Plastic Surgery Center will NOT be billing my insurance and that I am responsible for payment in full.

Patient Signature:_____ Date: _____

Print Name:_____