

Program Fee Policy Disclosure and Contract

Walter J. Chlysta MD, Inc.

I have sought medical care from Walter J. Chlysta MD and desire to undergo bariatric (obesity) surgery. I understand and agree to submit a NON-REFUNDABLE program fee of \$1,600 (one-thousand six hundred dollars) at the time surgery is scheduled.

I understand that Walter J. Chlysta MD, Inc. charges a fee of \$6500 for the LAPBAND and \$7500 for the Laparoscopic, possible open gastric bypass. If I am a self-pay patient, I understand that the program fee will be credited towards the above costs only. If I have health insurance coverage for bariatric surgery, I understand that the program fee will not be credited toward any deductible or co-payment that I may owe.

I understand that the program fee is used to help sustain the bariatric program, support group, information sessions and for additional costs associated with these entities. I understand that the program fee does not cover any other expenses such as dietician fees, hospital charges, anesthesia fees or any other expenses.

I understand that if I cancel or reschedule my surgery within two weeks prior to the scheduled date without a valid medical reason or reasonable, confirmable circumstance that I will be refunded only half of the program fee (\$800).

I understand the above policy and agree to it. I also state that I was notified of this policy in the information packet I received and at my first office visit. I understand that I could undergo surgery elsewhere where a program fee may or may not be charged.

Signature:

Date:

Print name:

Witness signature:

Date:

Witness name (print)