SURGICAL CANCELLATION POLICY, PAYMENT & CREDIT CARD AUTHORIZATION

HIPAA ACKNOWLEDGMENT & BINDING ARBITRATION AGREEMENT

Clinic Name: _____
Clinic Address: _____

DEPOSIT, PAYMENT & SCHEDULING TERMS

1. A **$2,500 NON-REFUNDABLE deposit** is required to secure your surgical date. This deposit is **non-refundable under all circumstances**, including but not limited to cancellation, failure to complete pre-operative requirements, travel issues, personal reasons, or changes in medical eligibility.
2. The **remaining balance is due no later than fourteen (14) calendar days prior** to the scheduled procedure date.
3. Failure to remit the full balance by the deadline will result in:
    - Immediate cancellation of the procedure
    - Forfeiture of the $2,500 deposit
    - An additional **$1,500 administrative fee**, charged to the credit card on file

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STRICT CANCELLATION POLICY

- **All cancellations for any reason result in forfeiture of the $2,500 non-refundable deposit.**
- Cancellations within **14 days of surgery**, same-day cancellations, or failure to appear (“no-show”) will incur an **additional $1,500 administrative fee**, charged to the card on file.
- Any medical exception is reviewed **solely at the clinic’s discretion** and does not guarantee refund or rescheduling.

RESCHEDULING POLICY

- **Patient-initiated rescheduling is NOT permitted.**
- Rescheduling may occur **only at the sole discretion of the clinic**, subject to operating room availability, staffing, and medical considerations.
- The clinic has **no obligation** to offer alternative dates.
- If approved, a reschedule may require a **new deposit and new booking agreement**.

PROCEDURE TIME LIMITATION

- All procedures must be completed within **six (6) months** of the original agreement date.
- Failure to complete the procedure within this timeframe results in **forfeiture of all deposits and payments made**.

FEES INCLUDED / EXCLUDED

Included in Surgery Fee:

- Surgeon Fee
- Anesthesia Fee
- Surgery Center Fee
- Implant(s)
- Pre-operative visits
- Post-operative care for **90 days** following surgery
- Select required garments

Not Included:

- Travel, lodging, transportation
- Medications
- Pre-operative clearance and laboratory tests
- Aftercare or recovery stays
- Additional or optional garments (including UroWrap)

Post-operative care beyond 90 days is billed separately.

CREDIT CARD AUTHORIZATION

By completing and signing below, you authorize **[Clinic Name]** to charge the credit card listed for:

- The $2,500 non-refundable deposit
- Remaining surgical balance
- Administrative, cancellation, no-show, or late payment fees

This authorization remains valid until all financial obligations related to your procedure are satisfied. Charges may be processed **without additional notice**, consistent with this agreement and Florida law.

CREDIT CARD INFORMATION (REQUIRED)

Cardholder Name (as shown on card):

Billing Address:

City _____ State _____ Zip _____

Card Type:
☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Card Number:

Expiration Date (MM/YY):
_____ / _____

CVV:

Cardholder Phone:

Cardholder Email:

CARDHOLDER AUTHORIZATION

I certify that I am the authorized cardholder or have legal authority to use this card. I understand that **chargebacks or payment disputes do not void this agreement**, and I remain financially responsible for all amounts due.

Cardholder Signature: _____
Date: _____

☐ I authorize the clinic to securely retain my card on file for authorized charges.

PATIENT ACKNOWLEDGMENTS

By signing this agreement, you confirm that:

1. You have discussed the risks, benefits, potential complications, alternatives, and the option of not undergoing surgery.
2. You will have a responsible adult present on the day of surgery and for at least 24 hours afterward, or you will arrange approved paid care.
3. Failure to complete required pre-operative clearance, labs, or documentation will result in cancellation with no refund.
4. You have disclosed **in writing** any prior penile or genital surgeries or procedures. Failure to disclose may result in cancellation at the surgeon's discretion, with full financial responsibility remaining with you.
5. You agree to view the required educational video prior to confirmation: https://www.youtube.com/watch?v=4FjI2Kxoxuk
6. Final surgical eligibility is determined by the surgeon.

HIPAA ACKNOWLEDGMENT

You acknowledge receipt of the clinic's **Notice of Privacy Practices** and consent to the use and disclosure of protected health information for treatment, payment, and healthcare operations in compliance with HIPAA.

BINDING ARBITRATION & WAIVER OF JURY TRIAL

Any dispute arising out of or relating to this agreement, treatment, or billing shall be resolved **exclusively through binding arbitration** conducted in the **State of Florida**, pursuant to the **Florida Arbitration Code** and the rules of the **American Arbitration Association (AAA)**.

You knowingly and voluntarily **waive the right to a jury trial**. Each party shall bear its own legal fees unless otherwise required by Florida law.

GOVERNING LAW & SEVERABILITY

This agreement is governed by the laws of the **State of Florida**. If any provision is found unenforceable, the remaining provisions shall remain in full force and effect.

ENTIRE AGREEMENT

This document constitutes the **entire agreement** between the patient and the clinic and supersedes all prior oral or written representations. No modification is valid unless in writing and signed by the clinic.

PATIENT SIGNATURE

Patient Name: _____ _____

Date: _____

Patient Signature: _____