

**Financial Agreement
For Cosmetic Procedures**

The patient is financially responsible for all cosmetic procedures. This office does not bill insurance companies for cosmetic procedures.

I, _____ state that I have requested a cosmetic procedure to be performed on _____ and I understand and agree to the following:

- I am financially responsible for the full cost of the procedure.
- The physician's office does not bill insurance companies for cosmetic procedures.
- I am to pay ½ cost of the procedure at time of scheduling and balance at time of the procedure.
- I may make payment by cash, cashier's check, personal check, MasterCard, Visa, American Express, Discover or Diner's cards.
- I understand that if I cancel this procedure with less than three (3) business days' notice, I will forfeit my deposit.
- I understand that if I fail to keep this appointment and do not call to cancel there is a \$50 **No Show** charge. This will be billed for the date of the missed appointment.
- I understand that this fee includes only this procedure and the follow up care related to this procedure.

Payment Schedule:

Procedure scheduled for _____		Initials _____
Deposit paid _____	Balance due _____	_____
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Patient Signature _____	Date _____	
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Witness Signature _____	Date _____	

Cancellation/No Show:

Should the patient cancel this procedure less than three (3) business days prior to the scheduled time, your deposit will be retained by the physician.

Procedure scheduled for _____

Reason: _____

Deposit fee retained: _____

Date _____

If any, Amount returned: _____

Date _____