(Practice Name)

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 that I understand and agree to the following:

- I am financially responsible for the full cost of the procedure.
- The office does not bill insurance companies for cosmetic procedures.
- I am to pay the full cost of the procedure_____days prior to the scheduled date. I may make payment by cash, cashier's check, personal check, MasterCard or Visa.
- I understand that if I cancel the procedure with less than_____business days notice, I will receive a refund of only 50%.
- I understand that this fee includes only this procedure and the follow-up care related to this procedure.

Payment Schedule: Initials

Procedure scheduled for _____ _____

Fee paid on _____ _____

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Cancellation:

Should patient cancel the procedure less than_____business days prior to the scheduled time, one-half of the procedure fee will be retained by the physician.

Procedure canceled on _____

Reason for cancellation _____

50% fee returned _____ _____
Amount Refunded Date Initials

_____ _____
Patient Signature Date