CONTOUR DERMATOLOGY
& COSMETIC SURGERY CENTER

TODAY'S DATE: _____

DATE OF PROCEDURE(S): _____

Financial Agreement For Cosmetic Procedures

The patient is financially responsible for all cosmetic procedures. This office generally does not bill insurance companies for cosmetic procedures. In the rare event the procedure is billed to insurance, you are responsible for any amount the insurance does not pay. This may include the full fee of the procedure.

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

- I am financially responsible for the full cost of the procedure. There are no refunds after procedure is complete.
- The Physician's office does not bill insurance companies for cosmetic procedures.
- I am to pay one-half the cost of the procedure upon scheduling the procedure, and the remaining balance is due on the date of the procedure prior to the procedure itself. I may make payment by cash, cashier's check, personal check, MasterCard, Visa, American Express, or Discover.
- I understand that if I cancel the procedure with less than ten (10) business days notice, I will not receive my 50% deposit. If I've already paid in full, then I will receive a refund of only 50%.
- I understand that I may reschedule my procedure only up to 5 business days prior to my originally scheduled appointment. If I must reschedule with less than five business days notice, I will forfeit my original deposit and must pay another deposit before being placed back on the schedule.
- I understand that this fee includes only the procedures listed below and the follow-up care related to them.

Review of Procedure(s) and Payment Schedule:

	Procedure and Areas	Fee $	**PT Initials**
Procedure 1 (include areas):			_____
Procedure 2 (include areas):			_____
Procedure 3 (include areas):			_____
Procedure 4 (include areas):			_____
Subtotal:	……		_____
Multiple Procedure Disc	(if applicable)……		_____
Total Due:	……		_____
50% Due Upon Scheduling:	……		_____
50% Due Prior to Procedure:	……		_____
Quote Expiration Date:	90 days from date of consult unless specified otherwise.		_____

_____ _____
Responsible Party Signature Date

_____ _____
Witness Signature Date

Consultation Performed By: _____ Date: _____

FOR OFFICE USE ONLY		**Staff Initials**
Deposit Amount Collected:	$ Deposit Date: / /	_____
Balance Due Before Procedure:	$	_____