

**Patient Financial Agreement**

1. I understand that the services or procedures rendered by Raminder Saluja, MD are completely cosmetic in nature and not covered by insurance.  No claims will be filed today or in the future for any cosmetic procedures.  For your convenience, we offer several payment options including: cash, personal check with driver’s license, debit card and credit card (MasterCard, VISA, Discover and American Express).  For those patients who qualify, third party financing is also available through Care Credit (for amounts greater than $300). Any refunds through Care Credit will be minus the 6% processing fee.

2. All consultations will be charged $25. If prescriptions are written or called into a pharmacy, a $25 fee will be charged.

3. Same Day Cosmetic Procedures- Full payment is due on the day that services are rendered.

4. We understand in some cases, scheduled appointments do occasionally need to be cancelled/rescheduled. We require a 24 advance notice to avoid a rescheduling/cancellation fee. Appointments scheduled for less than a 1 hour appointment time will be charged $25.

5. When an appointment of 1 hour or more is scheduled, a deposit reflective of treatment cost is collected to reserve your appointment. This deposit will be held on your account and applied toward any products or services in the office to be used within one year.  If the patient cancels their appointment within 48 business hours of the scheduled appointment or does not show for the appointment, the fee will be forfeited and will not be eligible for use toward products or services.

6. SCULPSURE, TRANSFIRM, (ex: Scarlet, Agnes, Neogen), EMSCULPT - a 10% deposit is required to secure an appointment. The remaining balance is due at the time of the laser procedure. If an appointment is cancelled or rescheduled 48 business hours or less from the scheduled treatment, the deposit will be forfeited.

9. A $25 rescheduling fee will be charged to patients who are unable to receive treatment due to tanned skin in treatment area.

I have received and understand these policies and I agree to the terms listed above.

**Print Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature (patient or responsible party)**