**Please initial each and sign below.**

*We wish to establish optimal relations with our patients and avoid misunderstanding regarding our payment and cancellation policies.*

***Payment is required for all services at the time of your visit.***

*\_\_\_\_\_\_\_As a note, any returned checks will immediately be sent to the county solicitor.*

*\_\_\_\_\_\_\_For those patients, applicable copayments and deductibles will be collected. Any amount that your insurance company deems your personal responsibility is due from you.*

**Applicable Deposits:**

**\_\_\_\_\_\_\_** I understand that for cosmetic procedures a non-refundable consult fee deposit of $80 is required at the time of scheduling.

**\_\_\_\_\_\_\_** I understand that if I am a self-pay patient, a non-refundable deposit of $150 is required at the time of scheduling each appointment.

**No Show and Late Cancellations:**

\_\_\_\_\_\_\_I understand that a minimum notice of one (1) business day is required to cancel or reschedule a standard office appointment. Failure to do so will result in a **$50 No Show fee** being assessed to me.

\_\_\_\_\_\_\_I understand that a minimum notice of two (2) business days is required to cancel or reschedule a cosmetic appointment or medical procedure. Failure to do so results in **loss of deposit** or **$100 No Show fee** being assessed to me.

\_\_\_\_\_\_\_For Profound, CORE, and TruSculpt 3D, I understand that a minimum of one (1) week notice is required to cancel.

Failure to provide this adequate cancellation notice results in **forfeiture of deposit**.

\_\_\_\_\_\_\_I also understand that three (3) No-Show infractions may result in dismissal from the practice.

**Note: Insurance Companies do not cover No Show penalties.**

*\_\_\_\_\_\_\_ I authorize electronic communications from Columbia Skin Clinic regarding any outstanding balances.*

*\_\_\_\_\_\_\_ Any balances past due 30 days will be sent to collections.*

***Are you covered by a Medicare QMB D-SNP or C-SNP plan? Yes \_\_\_\_\_ No \_\_\_\_\_***

*Your signature below signifies that you have read and understand the above consents and policies.*

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_**

*(If under 18 years of age, a responsible party must sign.)*