**YOUR PRACTICE**

**LOGO**

**COSMETIC SERVICE FINANCIAL POLICY**

Payment due at the time of your visit for services rendered, unless other arrangements have been made

**Private Patients:** We participate in many private insurance plans. This means that we accept the amount that these insurance companies **approve** as our full fee. You are still responsible for any co-payments, deductibles, share of costs and/or non-covered services.

You will receive a statement from this office as long as your account has an outstanding balance. This will show you all charges, payments, and adjustments that have been posted to your account. It will also indicate whether or not we have billed your insurance. Please review your statement each month and notify our billing office immediately if you feel an error has been made or if you have any questions concerning your balance. You may reach our billing office by calling **(xxx) xxx-xxxx**

Due to the nature of our medical specialty and our appreciation of the value of your time, it may be necessary in the event of an emergency or unforeseen delay to reschedule your appointment. We will always try to provide you with as much notice as possible and appreciate your patience and understanding.

**YOUR PRACTICE TAME requires a 24 hours’ notice if you are unable to keep your office visit appointment with us or you will be charged a $50.00 “no show” fee.**

By signing below, you are acknowledging that you have read this policy, understand it, and agree to abide by its terms.

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| --- | --- | --- | --- | --- |
| Signed |  | | DOB |  |
| Patient Name | |  | Date |  |