



Crutchfield Dermatology

**Pre-Payment of Cosmetic Services Policy and Agreement**

\_\_\_\_\_  
*PLEASE PRINT PATIENT'S NAME*

\_\_\_\_\_  
*Date of Birth*

***Pre-Payment of Services Agreement***

Appointment times for the procedure you have selected are very specific to allow for the proper time to be spent with each patient.

You have selected to have \_\_\_\_\_, an elective cosmetic procedure performed.

This procedure is not covered by insurance and is not eligible for flex plan reimbursement.

The cost of this procedure is \_\_\_\_\_. This quoted price is valid for 90 days.

50% of the amount due for the service described above will be collected at the time the appointment is made. The remaining 50% of the amount due will be collected at the time the service is rendered. A full refund of this amount will be given if the appointment is cancelled more than 5 business days prior to the appointment date. If you fail to cancel or reschedule your appointment with more than 5 business days' notice this will result in forfeiture of this entire 50% payment for the service. This forfeiture cannot be applied towards future treatment/s.

Crutchfield Dermatology reserves the right to modify any policies without notice.

**My signature below indicates that I have read and understand this policy and terms of this quote.**

  X    
\_\_\_\_\_  
**Patient or Responsible Party Signature**

\_\_\_\_\_  
**Today's Date**