MADRONA DERMATOLOGY

FINANCIAL POLICY
FOR COSMETIC PROCEDURES

The patient is financially responsible for all cosmetic procedures. This office does not bill insurance companies for cosmetic procedures.

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

- I am financially responsible for the full cost of the procedure.
- The office does not bill insurance companies for cosmetic procedures.
- I am to pay the full cost of the procedure on the day of the procedure. I may make payment by cash, check, VISA, MasterCard, American Express and Discover.

The procedure scheduled is _____.

The cosmetic fee for this procedure is_____.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date