

CHARLOTTESVILLE DERMATOLOGY PLC

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FINANCIAL AGREEMENT FOR COSMETIC PROCEDURES

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

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

- I am financially responsible for the cost of the procedure.
- This office does not bill insurance companies for cosmetic procedures.
- Full Payment is required at the time of service.
- I understand that skin types are different and may respond differently to treatment. I understand that typically multiple treatments are required to achieve the desired results.

Laser Company Treatment Guidelines	
Hair Laser - 5-7 treatments	IPL - 2-4 treatments
Fraxel - 3-4 treatments	

Initial Procedure: _____ Cost Per Treatment: _____

Patient Name (print): _____ Chart #: _____

Patient Signature: _____ Date: _____

(or Parent/Legal Guardian)

Witness: _____ Date: _____

Follow-up Treatments 1) _____ Date: _____

Follow-up Treatments 2) _____ Date: _____

Follow-Up Treatments 3) _____ Date: _____

