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# FINANCIAL POLICY AGREEMENT
# VERJU BODY CONTOURING AND CELLULITE TREATMENT

**PHYSICIAN CONSULTATION**

A consultation is required prior to therapy. It determines your eligibility for the therapy. It runs about 5 minutes. There is no fee for the consultation.

**VERJU TREATMENT**

- The Verju Therapy fee is due upon scheduling. The fee is non-refundable, non-exchangeable, and non-transferable.
- The paid service is **valid only for 6 months** from date of payment.
- We do not accept insurance. We do not provide procedure or diagnostic codes.

**Cancellation and Rescheduling Policy**

- We require at least 24 hours advance notice for cancellation and rescheduling.
- When rescheduling, the new appointment must be **within 2 months** from original appointment date. Otherwise, the appointment will be cancelled and the paid service will be forfeited.

**Missed/No Show Appointment Policy**: The session fee will be forfeited if a patient misses a scheduled session. It cannot be applied towards a future appointment.

**OFFICE POLICIES**

We do not participate with any insurance company. We do not give procedure or diagnostic codes, no exceptions. You are responsible for payment in full. FULL payment is due at the time of service.

Appointment cancellation/rescheduling may be done by phone. If you reach our voicemail, please leave your name, date of birth, and telephone number. You will be contacted to confirm the message. If you do not get a call-back, the message was not received.

The only exceptions to the Cancellation/Rescheduling and the Missed Appointment policies are true medical emergencies, or a natural disaster. A physician's note is required for documentation and consideration.

There is a charge for copies of medical records. A Medical Release Form must be completed. Completion of health-related forms and narrative reports for lawyers, for insurance purposes, etc. will be billed at our standard hourly rate. Please contact our office for updated rates.

Delinquent Accounts: All balances not paid following the rendered service will be considered delinquent and will be subject to a 3% monthly late charge until fully settled, with the patient's account reported to the collection agencies after 2 months of non-payment. Any collection or attorney's fees incurred because of a delinquent account will be the responsibility of the patient.

## FINANCIAL POLICY AGREEMENT

*I, (Patient Name) ______________________________________ (Date of Birth) ___________ have read, fully understood, and agree with the billing rates and the office policies, including the Cancellation/Rescheduling and Missed Appointment policies, noted in this agreement.*

I agree to pay the fee for the following treatment/s: (Place an X beside Fee Amount)

| BODY CONTOURING | Enter Fee | X | CELLULITE TREATMENT | Enter Fee | X |
|---|---|---|---|---|---|
| 3 Treatments Per Area | $ 920.00 | | Stage 1 (3 Treatments) | $ 320/area | |
| 6 Treatments Per Area | $ 1,600 | | Stage 2 (3 Treatments) | $ 580/area | |
| 9 Treatments Per Area | $ 2,320 | | Stage 3 (3 Treatments) | $ 760/area | |
| 12 Treatments Per Area | $ 2,700 | | | | |
| | | | | | |
| 3 Additional Treatments | $ 810.00 | | Additional Treatments | $ 120/treatment | |

I am aware that the fees are non-refundable**,** non-transferable, and non-exchangeable.

I am financially responsible for the billing charges incurred and/or services rendered, and authorize Advance Biomedical Treatment Center to charge my credit card account.

I agree to abide by this Financial Policy Agreement and the mandates stated above.

_______________________________________________ ___________________

Signature of Patient Date

_______________________________________________ ___________________

Signature of Parent / Guardian (If a minor) Date

Preferred Method of Payment:

___ Cash (U.S. Currency)

___ Visa / MasterCard: Name on Card: __________________________________________

Card no. ________________________________ Exp Date: ________ CVV______ Zip Code_______