

Family Health & Beauty Center

LASER TREATMENT AGREEMENT

I _____ have been notified and fully informed that the procedure to be done is a cosmetic procedure as defined by the insurance industry. I understand that cosmetic procedures/services are determined to be “not medically necessary”. Neither I, nor anybody on my behalf, may file this procedure with any insurance company for payment or reimbursement. I hereby agree to be held personally and fully responsible for payment.

I understand that payment is due in full at each visit. Any additional procedures done at my request during the visit will be billed accordingly. The payments for the procedures are non-refundable.

I have read and understand the above stated policy.

Patient Name: _____ Date: _____

Patient Signature: _____