MARINA PLASTIC SURGERY by Athenix

4560 Admiralty Way, Suite 108/255/256
Marina del Rey, CA 90292
P: 310.827.2653 · F: 310.823.1984

BOOKING & CANCELLATION POLICY

We take pride in the appropriate reservation of your procedural date and time! Our priority is to schedule procedures that can be attended to with the utmost of care. Surgical "No Show" or Cancellation within 24 hours will forfeit surgical booking fee and payment for non-surgical "No Show" or cancellation within 24 hours will be processed using credit card provided.

NON-SURGICAL CANCELLATION FEES:

- Consultation: $100
- Services 30 mins to 1 hour: $250
- Services 2 hours or longer: $500
- Packaged services will result in a loss of a treatment of the scheduled service.
- Membership/Loyalty patients will be debiting the cost of the service booked.

Payment of fees as mentioned above are charged after "No Show". Signature of this form authorizes this charge.

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Regarding surgery scheduling, this requires careful planning and coordination between our office, the Surgery Center, and their operating room staff, as well as your anesthesiologist, if applicable. In addition, special medical instrumentation is prepared and sterilized for each individual procedure. Therefore, please understand the importance of respecting our "Three-week Cancellation Policy" which entails the following:

SURGICAL CANCELLATION FEES:

- 15–21 days prior to your appointment date will result in a 25% loss of all fees
- 8 – 14 days prior to your appointment date will result in a 35% loss of all fees
- 7 days or less from your appointment date will result in 50% loss of all fees
- 2 day or less from your appointment date will result in 100% loss of all fees

Payment for surgery (which includes the surgeon's fee, the O.R. facility fee, and the anesthesia fee) must be received in full by certified check or credit card, three (3) weeks prior to your surgery date. This would also apply for any post-operative care facility, in the event you had reservations.

Thank you for your cooperation and understanding in this matter.

I have read, understand, and accept the above policies.

PATIENT NAME (PRINT) _____ **DATE** _____

PATIENT OR DESIGNATED REPRESENTATIVE SIGNATURE _____

PHYSICIAN SIGNATURE _____ **DATE** _____