CANCELLATION POLICY
for
Office Procedures and/or Surgery

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.

Policy for non-surgical procedures:

- Payment for certain non-surgical procedures will be taken at the time of scheduling to secure your appointment (i.e.…Thermacool)
- Cancellations three (3) days prior to your procedure(s) will result in a charge to your account of 50% of that procedure (including Thermagel, laser procedures, injectables, permanent makeup, facials, etc.).
- Cancellations (or simply Not Showing) on the day of the procedure, will result in a charge to your account of 100% of that procedure.
- Scheduled treatments on prepaid packages will result in debit of treatment from series if appointment is cancelled within 3 days.
- All balances must be paid prior to scheduling any future appointments.

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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:

- Cancellation 15–21 days prior to your procedure date will result in a 25% loss of all fees
- Cancellation 8 – 14 days prior to your procedure date will result in a 35% loss of all fees
- Cancellation 7 days or less from your procedure date will result in 50% loss of all fees
- Cancellation 1 day or less from your procedure 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,
W. Grant Stevens, MD, FACS-Medical Director

I have read, understand and accept the above policies.

Printed Name:____

Signature: ____ Date:______________

Witness: ____ Date:______________