Aesthetica Cosmetic and Laser Surgery Center, P.C.
1342 Chelsea Ave., Rear | Bethlehem, Pa. 18018
Phone: (610) 861-9469
David B. Vasily, M.D., Medical Director

Financial and Insurance Policy

- **It is the policy of Aesthetica Cosmetic & Laser Center to have a Financial and Insurance Policy that clearly outlines patient and practice responsibilities. We are committed to providing our patients with optimal care when addressing your aesthetic and medical concerns. This Financial and Insurance Policy was created in an effort to avoid any misunderstandings or disagreements concerning payment and/or coverage for professional services.**

Please read the following carefully:

1. **Aesthetica does not accept or participate in any insurance plans nor are we responsible for prescription plan coverage:**

   a. Treatments provided at Aesthetica are not able to be submitted to insurance companies.
   b. Aesthetica does not have knowledge as to whether or not a prescription given to the patient will be covered by the patient's insurance plan. The prescription given is the prescription that Dr. Vasily feels is best suited for your medical concern(s). If you are unable to attain a prescription written by Dr. Vasily due to coverage and/or cost; you may contact your insurance agent or provider to request a copy of your prescription formulary. The patient is responsible for knowing their own prescription formulary. Once you have obtained the prescription formulary, kindly contact our office with the information and Dr. Vasily will review your formulary and provide you with a prescription that meets your insurance company's requirements.
   c. We do not write pre-authorizations for prescriptions. If your insurance company rejects a prescription and requests a pre-authorization; kindly provide our office with your prescription formulary and we will have Dr. Vasily review the formulary for a covered prescription.

Consent for Financial Responsibility of Non-Covered Services

I understand that all services performed at Aesthetica Cosmetic & Laser Center are considered cosmetic and not covered or reimbursed by my insurance carrier. I agree to be financially liable for any payments incurred for these services.

Patient Signature:_____ Date:_____

2. **Patient Financial Responsibility:**

a. Payment is due at the time of service and/or at the time the product(s) are received.
b. Payment Options: Cash, checks and all major credit cards (Visa, MasterCard, Discover, American Express.)

PLEASE NOTE: If paying by check, there is a $40 fee for all returned checks. A $25 administration fee if the account is forwarded to collections for non-payment.

c. Any accounts that remain outstanding, whether for a procedure fee or a cancellation fee will be forwarded to the collection agency after 5 consecutive billing cycles.
d. NO INTEREST[1] Payment Plans[2] from CareCredit®.
   - Convenient, low monthly payment plans are available.
   - No annual fees or pre-payment penalties.
   - Prior approval is required. You are welcome to inquire at the front desk for more information on this plan.

[1] If paid within the 6-month promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
[2] Subject to credit approval.

Cancellation Policy

a. Our office policy for cancellations is a 48-hour notice. Outlined below is our policy on less than a 48-hour notice of cancellation and for any missed appointments in our office.

• Missed Consultation appointment with Dr. Vasily	$100
• Missed Consultation appointment with Emily, R.N.	$ 50
• Missed follow up appointment with Dr. Vasily, Emily R.N. or technician	$ 50
• Missed treatment appointment with Dr. Vasily, Emily R.N. or technician	$100
• Cancellation notice is less than 48 hours:	$ 50

My signature on this document confirms that I have read and will adhere to Aesthetica Cosmetic & Laser Center Financial and Insurance Policy and the Cancellation Policy.

Patient Signature:_____ Date:_____

Print Name:_____

Advanced Laser Procedure Deposit & Cancellation Policy Consent

To reserve your procedure appointment, a **50% non-refundable deposit of $_____** is required at the time of booking. Your deposit will be applied toward the total cost of your procedure.

Because procedure appointments require dedicated time, preparation, staffing, and resources, the deposit is **non-refundable** and may be forfeited if you cancel or reschedule outside of the terms outlined below.

Cancellation & Rescheduling

- Appointments may be cancelled or rescheduled with at least **48 hours' notice** without forfeiting your deposit.
- Cancellations or rescheduling with less than **48 hours' notice** will result in forfeiture of the deposit.
- **No-shows** will result in forfeiture of the deposit.
- Arriving too late to safely or appropriately perform the procedure may be considered a cancellation and may result in forfeiture of the deposit.
- A new deposit may be required to schedule a future appointment.
- Repeated cancellations or rescheduling may require a new deposit or additional payment to secure future appointments.

Credit Card on File

As part of scheduling your procedure, you authorize the practice to securely maintain your credit card information on file. You authorize the practice to charge the card on file for **forfeited deposits, applicable cancellation or no-show fees, or other charges that you have specifically authorized** under this policy.

Your card information is securely stored through our payment processing system and is not maintained directly by the practice.

Practice Discretion

We understand that unexpected circumstances may occur. In the event of a true emergency or extraordinary circumstance, the practice may, at its discretion, make an exception to this policy. Exceptions are not guaranteed and will be evaluated on an individual basis.

By submitting a deposit and providing your credit card information, you acknowledge that you have read, understand, and agree to the terms of this Procedure Deposit & Cancellation Policy, including authorization for the practice to retain your card on file and process applicable charges as outlined above.

Patient Signature: _____ **Date:** _____

CC# _____ **Exp. Date:** _____ **Code:** _____

Witness: _____ **Date:** _____