



## **Financial Policies**

### **Complimentary Consultation**

There is no fee for a consultation. At that time, the provider will discuss treatment options and associated costs. If there is time and you choose to receive treatment, payment will be owed at the end of your treatment.

### **Payment Methods**

We accept payment by cash, check, Visa, MasterCard, American Express and Care Credit. Payment is due at the time of service. For more information about payment with no interest for 6 months, please see the section on Care Credit Financing below.

### **Care Credit Financing**

We are pleased to offer our patients the Care Credit card, North America's leading patient payment program. The Care Credit card is just as easy to use as a regular credit card, but it's designed specifically for your health and beauty needs. We offer 6 month no interest payment plans from Care Credit. You can even use your Care Credit card over and over for follow-up appointments.

### **Returned Check Fee**

There is a service charge of \$25.00 for each check returned to our office for insufficient funds or any other reason. If this should happen, your account may be subject to cash and credit card only.

### **Appointment Cancellation/No-Show Fees**

Since we are often unable to fill appointments canceled with little or no notice, a \$75.00 cancellation fee will be incurred for no-show appointments or appointments that are canceled with less than 24 hours-notice.

### **Package Pricing & Payment**

Occasionally, we may offer package specials. Payment for the entire package is due at the time of the first treatment. We will not bill per treatment.

I, the undersigned, have read the above and realize that all charges incurred to me or my dependents for services or products rendered by Generations Family Practice/Generations Medical Aesthetics are my responsibility. All court fees or other fees necessary to collect on this account are my responsibility.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Patient Signature or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (if not self)