STEPHENS CITY
convenience clinic
AESTHETICS

160 Warrior Drive, Stephens City, VA 22655
Phone: 540-508-4539 | Fax: 540-508-4441
www.scfmcc.com

Statement of Financial Responsibility for Cosmetic Procedures

The patient is financially responsible for all cosmetic procedures.

I, ________________________state that I have requested the following cosmetic procedure, ______________________________ to be performed on ______________________, and I understand and agree to the following:

- I am financially responsible for the full cost of the procedure when services are rendered.
- Cosmetic procedure insurance claims cannot be filed either by our office or the patient.
- I understand this fee includes only the procedure for today.

We gladly accept CASH and CREDIT CARDS. NO REFUNDS OR EXCHANGES ON ALL PRODUCTS OR SERVICES PURCHASED.

____ ______________

Signature of Patient or Responsible Party Date

Acknowledgement of Receipt of Notice of Privacy Practices

We are required to advise you of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. A copy of the Notice of Privacy Practices will be provided upon request.

I acknowledge that I have been made aware of this office's Notice of Privacy Practices.

____ ______________

Signature of Patient or Patient's Representative Date

Photographic Consent:

I give consent to be photographed for the purpose of medical records: Yes No
I give consent to be anonymously photographed for marketing and/or publication: Yes No

____ ______________

Signature of Patient or Patient's Representative Date