THE NEW YORK
AESTHETIC CONSULTANTS
PLASTIC, LASER & DERMASURGERY

DERMASURGERY
RON M. SHELTON, M.D., F.A.A.D.

PLASTIC SURGERY
TED CHAGLASSIAN, M.D., F.A.C.S.
WILFRED BROWN, M.D., F.A.C.S.

# Financial Policy for Non-Surgical Procedures

- The balance of the procedure fee must be paid at least 2 weeks prior to the procedure date.
- The consultation fee of $150 will be waived for any procedure over $500 that is paid in full on day of the consultation, or it will be applied towards a procedure that is performed within 3 months after the consultation. Procedure fee quotes are valid for 3 months and include all pre- and post-procedure visits.
- A non-refundable deposit of $500 is required for any procedure over $2,000 on the day a procedure is scheduled. If your procedure date needs to be rescheduled due to an emergency, this deposit will be reapplied towards a new procedure date. A procedure that is rescheduled more than once will require an additional non-refundable deposit of $500.
- A deposit of $700 is required for Sculptra treatment at the time of scheduling an appointment. Deposit will be refunded only if a 48 hr appointment cancellation notice was given to the office and if Sculptra was not yet prepared for the patient's treatment at the time of cancellation.
- The NYAC accepts payment by cash, bank check, MasterCard, Visa, Discover, American Express, and financing options through CareCredit, a leading healthcare credit card. Discounts and promotions will not apply if payment is made with CareCredit credit card. Bank checks must be made payable to The New York Aesthetic Consultants. Personal checks are not accepted.
- If you cancel the procedure within 2 weeks of the scheduled procedure date, 25% of the Physician's fee and the $500 deposit will be retained by the NYAC. If you cancel the procedure within a week or less of the scheduled procedure date, 50% of the Physician's fee and the $500 deposit will be retained by the NYAC.
- All refunds must be approved by the NYAC Practice Administrator. Refunds will be made within 30 days from date of the request. In the event of a refund request for a payment made by credit card, a deduction of 5% will be retained by the NYAC.

Mastercard_____ Visa _____ American Express _____ Discover _____

Card #_____

Exp_____/_____Security ID # (3-4 digits, on back of card) _____

Card Holder _____

**I hereby authorize The NYAC to charge my credit card and hereby confirm I will not dispute this charge with my credit card company. Signature_____**

***By signing below, I acknowledge I have read and agree to the above policy terms and conditions.***

Patient Name: _____

Patient/Legal Guardian Signature: _____Date: ____/_____/_____