



5500 Dr MLK Jr St North ♦ St Petersburg FL 33703
Phone: 727-525-5500

FINANCIAL CONSENT & RESPONSIBILITIES

I understand that this is an elective cosmetic procedure and that Liposelection only by VASER® is not covered by insurance, therefore placing full responsibility of payment upon myself. I understand that Liposelection by VASER® is not an exact science and that there are no guarantees or assurances given to me concerning the results of the procedure.

The price quoted at time of consultation is valid for up to 30 days since cost of supplies and equipment can change frequently with the manufacturers. The price quoted at consultation includes the pre-operative visit, the procedure itself and the following post-operative visits: post-op day 1, 1 week follow-up, 3 month follow-up, 6 month follow-up, and 1 year follow-up.

I understand that additional costs occur with any secondary surgery; touch ups or post treatment procedures other than liposuction (i.e. Endermologie, Laser Treatments, Massage, etc.) as well as any other post operative visits with the physician or medical staff other than the visits mentioned previously. Compression garments, prescription medications, and medical supplies needed for at home dressing are not covered in the cost of the procedure.

I hereby accept responsibility for payment for any service(s) provided to me. My signature below indicates that I am financially responsible for all charges incurred, that I understand that all charges are collected at the time of the pre-operative visit to reserve my time for the procedure.

I understand that if I cancel a procedure by giving notice 3 weeks or greater, Simply Lipo will retain 10% of the procedure cost. If notice is given less than 3 weeks, Simply Lipo will retain 20% of the procedure's cost. In the event that I do not show up for my procedure on the scheduled day of procedure, Simply Lipo will retain 100% of the procedure's cost. In the event that I am late for my procedure by 1 hour or greater, Simply Lipo will require the additional charge of 20% of the procedure's cost as a reschedule fee and I understand I will be rescheduled at the first available time slot.

By signing this form, I acknowledge that I have read this form and I fully understand its content. I have been given ample opportunity to ask questions and that all the questions have been answered to my satisfaction. I understand that I can call or return to the office at any time to ask for more information from the doctor or from the medical staff.

I will pay by (check one) cash check credit card care credit

Credit Card Number: _____ Exp: Date _____

Security Code: _____ (Shown on reverse side of card in the signature label)

Credit Card Authorization Name Print: _____ Signature: _____

SIGNATURE OF PATIENT

DATE