Ciao Bella

Medical Center And Spa

Patient Financial Responsibility Agreement

YOU MUST PROVIDE YOUR PICTURE IDENTIFICATION TO THE RECEPTIONIST FOR PHOTOCOPYING AT EACH APPOINTMENT. THIS ACCOUNT IS SELF-PAY, AND PAYMENT IN FULL IS DUE AT THE TIME OF EACH SERVICE.

I clearly understand and agree that all services rendered to me may be charged directly to me, and that I am personally responsible for full payment. I understand that even if I suspend or terminate treatment, any fees for professional services rendered to me or to my dependent up to the point of termination will be immediately due and payable.

I acknowledge that I am responsible for any outstanding fees for services provided to me by (Ciao Bella Medical Center & Spa) ("**Practice**").

Any other arrangements that may involve a payment plan or payment deferral must be made in writing with the office manager or business manager of the Practice. Verbal agreements are not acceptable.

I acknowledge that the Practice reserves the right to charge a fee if I do not attend or cancel the scheduled appointment without providing 24-hour prior notice to the Practice. I further acknowledge that the Practice reserves the right to reschedule my appointment if I am more than 15 minutes late to the scheduled appointment.

Printed Patient Name **Date** **Signature of Patient**

Practice Representative Name **Signature of Practice Representative**