FINANCIAL POLICY FOR COSMETIC SURGERY

Dear (Patient Name) ____,
Your procedure(s) ____,

Will cost a total of $____.

Our policy regarding payment(s) for this procedure is as follows:

• 50% of your procedure cost is due upon booking surgery. Of that amount, $1,000 is a non-refundable deposit

• The remaining balance must be paid in full, 1 month prior to your surgery date.

PLEASE NOTE THAT A FAILURE TO HAVE ALL PAYMENTS MADE PRIOR TO SURGERY WILL RESULT IN CANCELLATION OF YOUR SURGERY DATE.

Remaining payment of: __________________________ Due on: __________________________________

Methods of acceptable payment include:
• Certified cheque, payable to Dr. Kara Medicine Professional Corporation
• Debit, VISA, MasterCard, American Express or Money Order
• Financing Companies such as Medicard and Healthsmart

If you wish to pay by credit card over the phone, you understand that you are authorizing us to do so and will be responsible for your action and by signing below you release Dr. Kara, his staff and Dr. Kara Medicine Professional Corporation from any liabilities of any form.

THERE WILL BE A 20% CANCELLATION CHARGE SHOULD YOU CANCEL WITHIN 72 HOURS OF YOUR SCHEDULED SURGERY- IN ADDITION TO THE $1,000 NON REFUNDABLE DEPOSIT.

UNLESS OTHERWISE ADVISED, YOU ARE TO COME TO YOUR SURGERY NPO (NOTHING TO EAT, DRINK, SMOKE, GUM, MINTS, ETC). NOT COMING NPO WILL RESULT IN A CANCELLED SURGERY AND A $1,000 REBOOKING FEE.

I HAVE READ, DISCUSSED AND UNDERSTAND THE INFORMATION REGARDING THIS FINANCIAL POLICY.

(Patient Signature) ____ (Date) __________________________

(Coordinator or Witness) ___________________________________ (Date) __________________________