Patient Financial Responsibility Agreement

YOU MUST PROVIDE YOUR PICTURE IDENTIFICATION TO THE PRACTICE 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 Bella Bloom Medspa, PLLC ("**Practice**").

Any other arrangements that may involve 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 of $50.00 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**