CONTRACT OF FINANCIAL RESPONSIBILITY

In agreeing to be responsible for your medical care, Four Corners Laser & Aesthetics requires that you be responsible for your financial obligations to us.

Please read the following carefully and initial each paragraph, then sign where indicated to acknowledge your understanding and acceptance. If you are a minor (under 18), your parent or legal guardian must accept financial responsibility on your behalf.

1. ____ I understand and accept that ultimately I am financially responsible for all services provided to me by Four Corners Laser & Aesthetics.

2. ____ I understand and accept that Four Corners Laser & Aesthetics might not accept my particular insurance. (*FCL&A will gladly give you a copy of the super bill so you can submit it to your insurance company*).

3. ____ I understand and accept that I will be assessed a $35.00 fee for any returned checks (After second attempt). Any payments thereafter must be made with cash or credit cards.

4. ____ I understand that I will be assessed a $35.00 fee if I fail to keep my scheduled appointment(s) or fail to cancel my scheduled appointment(s) within 24 hours.

5. ____ (If applicable) I understand and accept that my pap specimen will be sent to Cedar Diagnostics for pathology testing. In compliance with the A.C.O.G. standard of care, any abnormal pap results will automatically be reflex tested for the Human Papilloma Virus (HPV). I understand that the individual hospital will bill me for this lab test and that *Four Corners Laser & Aesthetics* has no control over this billing. If I have a problem with this billing, I understand I must contact the individual hospital billing office to resolve it.